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ROYAL COMMISSION OF INQUIRY INTO CERTAIN  
DEATHS AT THE HOSPITAL FOR SICK CHILDREN AND  
RELATED MATTERS.

Hearing held  
8th floor  
180 Dundas Street West  
Toronto, Ontario

The Honourable Mr. Justice S.G.M. Grange

Commissioner

P.S.A. Lamek, Q.C.

Counsel

E.A. Cronk

Associate Counsel

Thomas Millar

Administrator

Transcript of evidence  
for  
February 6, 1984

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ROYAL COMMISSION OF INQUIRY INTO CERTAIN  
DEATHS AT THE HOSPITAL FOR SICK CHILDREN  
AND RELATED MATTERS.

Hearing held on the 8th Floor,  
180 Dundas Street West, Toronto,  
Ontario, on Monday, the 6th day  
of February, 1984.

THE HONOURABLE MR. JUSTICE S.G.M. GRANGE - Commissioner  
THOMAS MILLAR - Administrator  
MURRAY R. ELLIOT - Registrar

APPEARANCES:

E. CRONK	Commission Counsel
D. HUNT ) L. CECCHETTO)	Counsel for the Attorney General and Solicitor General of Ontario (Crown Attorneys and Coroner's Office)
I.J. ROLAND) M. THOMSON ) R. BATTY )	Counsel for The Hospital for Sick Children
B. PERCIVAL, Q.C.) D. YOUNG )	Counsel for The Metropolitan Toronto Police
W.N. ORTVED	Counsel for numerous Doctors at The Hosiptal for Sick Children
F. KITELY	Counsel for the Registered Nurses' Association of Ontario and 35 Registered Nurses at The Hospital for Sick Children
H. SOLOMON	Counsel for The Ontario Registered Nursing Assistants

(Cont'd)...







APPEARANCES:

D. BROWN	Counsel for Susan Nelles - Nurse
E. FORSTER	Counsel for Phyllis Trayner - Nurse
B. KNAZAN	Counsel for Mrs. M. Christie - R.N.A.
S. LABOW	Counsel for Mr. & Mrs. Gosselin, Mr. & Mrs. Gionas, Mr. & Mrs. Inwood, Mr. & Mrs. Turner, Mr. & Mrs. Lutes, and Mr. & Mrs. Murphy (parents of deceased children)
F.J. SHANAHAN	Counsel for Mr. & Mrs. Dominic Lombardo (parents of deceased child Stephanie Lombardo); and Heather Dawson (mother of deceased child Amber Dawson)
W.W. TOBIAS	Counsel for Mr. & Mrs. Hines (parents of deceased child Jordan Hines)
J. SHINEHOFT	Counsel for Lorie Pacsai and Kevin Garnet (parents of deceased child Kevin Pacsai)





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--- Upon commencing at 10:00 a.m.

THE COMMISSIONER: Yes, Miss Cronk.

MS. CRONK: Good morning, sir.

Before we begin with our next witness,  
Mr. Commissioner, there is a further document that  
we would like to file. I should say immediately  
that the Hospital provided this to us some time ago  
and we neglected to mark it. It is an out-patient  
medical chart for Jesse Belanger and there is a  
covering letter from Mr. Roland on behalf of the  
Hospital explaining how this second medical record  
was found. I would point out it was provided to us  
many months ago and we simply neglected to file it  
and I would like to do so, sir, at this time.  
Jesse Belanger's main medical chart has been  
marked as Exhibit 79 and perhaps it would be  
appropriate to mark it 79A.

THE COMMISSIONER: 79A, yes.

---EXHIBIT NO. 79A: Out-Patient Medical Chart  
Jesse Belanger and letter  
July 11, 1983 from Mr. I.J.  
Roland to Mr. P.S.A. Lamek, Q.C.

MS. CRONK: Our next witness, sir,  
is Ms. Bertha Bell.

MS. BERTHA BELL, Sworn

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DIRECT EXAMINATION BY MS. CRONK:

Q. Ms. Bell, as I understand it you received your registered nursing diploma from Ryerson Polytechnical Institute in Toronto in 1977, is that correct?

A. That is correct.

Q. You had previously been a registered nursing assistant?

A. That is correct.

Q. How long were you a registered nursing assistant before completing your registered nursing degree?

A. Just under six months.

Q. I'm sorry, I can't hear you.

A. Just under six months.

Q. Where did you work as a registered nursing assistant?

A. Doctors' Hospital.

Q. Is that in Toronto?

A. Yes.

THE COMMISSIONER: I think, Ms. Bell, this sort of thing always happens and we have to adjust ourselves to the microphone, that might mean bringing it into you or bringing you up to it, I don't know.





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MS. CRONK: Q. From April of 1976 until May 1978 you worked as a Staff Nurse and a Team Leader at Doctors' Hospital then in Toronto?

A. That is correct.

Q. And subsequently after you received your Registered Nursing Diploma you worked at that Hospital as a Registered Staff Nurse?

A. That's right.

Q. Did you work in pediatrics at Doctors' Hospital?

A. No, I worked with adults in the surgical area.

Q. In the surgical area?

A. Yes.

Q. So you were not working in cardiology?

A. No.

Q. Then in November 1978 as I understand it you joined the nursing staff at the Hospital for Sick Children?

A. That is correct.

Q. And you worked initially as a Staff Nurse on the Cardiology Ward, Ward 5A?

A. That is right.







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2

3

Q. Were you a member of the nursing team while you were on Ward 5A, Ms. Bell?

4

5

A. I was a member of a nursing team, yes.

6

Q. Whose team was it?

7

8

A. Diane Crosswell was the team leader.

9

10

11

Q. And you worked on that ward as I understand it until April of 1980 when we have heard that the cardiology units were transferred to Wards 4A and 4B?

12

A. That is correct.

13

14

Q. Did you transfer with the other members of the cardiology unit to Wards 4A and 4B?

15

16

A. Yes, I did.

17

18

Q. What was your position after the wards had been relocated?

19

20

A. Team leader.

21

22

Q. And were you a team leader on 4B at that time?

23

24

25

A. Yes, I was.

Q. Were you a team leader on Ward 4B from the period April 1980 through to the end of March, 1981?







1

2

A. Yes, I was.

3

4

5

6

Q. In order to become a team leader on Ward 4B with the relocation, Ms. Bell, were you required to take a team leader course at the Hospital for Sick Children?

7

A. Yes, I did.

8

Q. How long did that course last?

9

A. It lasted about six weeks, in the summer.

10

Q. I am sorry?

11

A. In the summer of 1980.

12

Q. That is when you took it?

13

A. Yes.

14

15

Q. Did any other members of the nursing staff from the cardiology unit take the team leader course at the same time that you did?

16

A. Phyllis Trayner.

17

18

Q. Did Susan Nelles take it at the same time?

19

A. No, she did not.

20

21

Q. And in July of 1981 as I understand it you took maternity leave from the Hosiptal for Sick Children?

22

23

A. Yes, I did.

24

Q. And when you left you were

25





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holding the position of team leader on Ward 4B?

3

A. That is right.

4

5

Q. You then subsequently returned  
after maternity leave to the Hospital for Sick  
Children?

6

7

A. Yes, I did.

8

Q. When was that?

9

A. In January of 1982.

10

Q. And are you still employed at  
the Hospital for Sick Children?

11

A. Yes, I am.

12

13

Q. When you returned in January  
of 1982 to which ward were you assigned?

14

A. 7A.

15

Q. And what kind of a ward is  
that?

16

17

A. It is an infant medical/surgical  
ward.

18

19

Q. Is that where you are currently  
working?

20

A. Yes, I am.

21

Q. Are you a team leader now on  
that floor?

22

23

A. I am occasionally in charge  
but I am not a team leader now.

24

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Q. So you are working as a Staff  
Nurse on that ward?

4

A. That is right.

5

6

Q. As I understand it you have  
also gone back to school on a part time basis?

7

A. Yes, I have.

8

9

Q. You have enrolled in a  
Bachelor of Applied Arts degree in nursing at  
Ryerson?

10

A. Yes, I have.

11

12

Q. And you are currently enrolled  
in that program?

13

A. That is correct.

14

15

16

17

Q. Your counsel was kind enough  
to provide me with a copy of your curriculum vitae.  
Could you just review it for a moment please and  
tell me if it sets out your background qualifications  
and employment history that you have just reviewed?

18

A. That's right.

19

THE COMMISSIONER: 341.

20

21

---EXHIBIT NO. 341: Curriculum Vitae re Bertha  
Bell.

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MS. CRONK: Q. Ms. Bell, I would  
like initially to review with you what your duties





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and responsibilities were as a team leader on 4B.  
As I understand it while you were a team leader on  
4B you reported to Mary Costello the head nurse  
for that ward?

6

A. Yes, I did.

7

8

9

Q. And you were responsible I  
take it for overseeing the performance and the  
execution of the responsibilities of the various  
members of your own team?

10

11

A. I did.

12

13

14

Q. All of the questions that I  
am going to direct to you, Ms. Bell, unless I indicate  
otherwise apply to the period July 1980 through to  
the end of March 1981.

15

A. All right.

16

17

18

Q. Can you help me please in  
general terms what your duties and responsibilities  
were during that nine-month period as a team leader  
on Ward 4B.

19

20

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A. I would plan patient care and  
help implement patient care; evaluate the care given  
by myself or by members of my team. There were  
certain teaching responsibilities as well for newer  
team members, orienting them to the equipment or  
any kind of new procedures that we did. To make







1  
2 rounds with doctors; to carry out doctors' orders;  
3 and make sure that they are carried out amongst the  
4 team members. There would also be, on the weekend,  
5 we would be in charge so we would do patient assign-  
6 ments, and as well during the week if there was a  
7 change in the number of patients that we had, or  
8 if their condition changed we would change the  
9 patient assignments as well. I can't think of any-  
10 thing else.

11 Q. Ms. Bell, I'm interested as well  
12 in the identity of the members of your own team  
13 through this nine-month period, and it may be helpful  
14 for you to have, Mr. Registrar, if you would please,  
15 Exhibit 334, which are the WIN sheets for Ward 4B  
16 that have been marked, Ms. Bell, for this nine-month  
17 period.

18 A. Okay.

19 Q. Ms. Bell, if we can start  
20 please with June 29th, 1980, that is the first  
21 WIN sheet that has been marked. As I read the  
22 WIN sheet the members of your team at that time  
23 were Miss Harder who is a registered nurse.

24 A. Yes.

25 Q. Is that correct?

A. That is correct.





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Q. Mary Anne Bracewell who was also a registered nurse, and Yvonne Lyons who was a registered nursing assistant, is that correct?

A. That is correct.

Q. Then as I understand it Miss Harder subsequently appears to have resigned, and I will refer to the WIN sheet for July 8th, 1980.

A. That is right.

Q. Did Ms. Harder leave the team at that time?

A. That is correct.

Q. So at that stage would I correctly assume that your team was comprised of two registered nurses, namely yourself and Mrs. Bracewell and one registered nursing assistant namely Yvonne Lyons?

A. That is correct.

Q. And did that subsequently change as well?

A. Yes.

Q. Could I refer you to the WIN sheet for August 13th, 1980. Please correct me if I am wrong, Ms. Bell, but it appears to me on my review of this WIN sheet that your team remained the same, that is there were three of you until we







1  
2  
3 come to August 13th, and then it appears that  
4 Miss Mary Jean Halpenny joins your team.

5 A. That is correct.

6 Q. Is she a registered nurse as  
7 well?

8 A. Yes, she is.

9 Q. Was she at that time?

10 A. Yes, she was.

11 Q. And again if we move through  
12 the WIN sheets for the period immediately following  
13 that, it appears that Miss Halpenny intermittently  
14 works on the same shift as you do along with  
15 Mrs. Bracewell and Miss Lyons, but then we come to  
16 the week of September 1st.

17 A. Okay.

18 Q. Am I correct in concluding  
19 from the September 1st WIN sheets and those which  
20 follow after that, that at that time during that  
21 week Miss Halpenny began to work the same shift as  
22 both yourself and the other team members on your  
23 team on a regular basis?

24 A. That is correct.

25 Q. And that continued as I under-  
stand it through until January of 1981?

A. That is correct.





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Q. So that throughout the fall of 1980 you had the same three team members, but in addition Miss Halpenny, until we come I suggest to the week of January the 19th, and I would ask you to turn to that WIN sheet if you would.

A. Okay.

Q. Do you have that?

A. Yes, I do.

Q. And there was another change to your team at that time?

A. Yes, there was.

Q. Can you help me as to what the change was?

A. Susan Reaper was helping.

Q. Was Miss Reaper a registered nurse?

A. Yes, she was.

Q. Did Miss Halpenny leave the Hospital or merely your team?

A. Just my team.

Q. And it appears to me looking at that WIN sheet that she in fact joined Karen Power's team, another 4B team?

A. That is correct.

Q. So from that point forward then,







1  
2 starting that week, your team was comprised I suggest  
3 of Mrs. Bracewell, Miss Lyons, Miss Reaper and  
4 yourself?

5 A. That is correct.

6 Q. And then if we continue to  
7 move through the WIN sheets it appears to me, and  
8 please correct me if I am wrong, that during the  
9 week of March 2nd, 1981 there is yet another change.

10 A. That is correct, I have got.

11 Q. So if we look for example to  
12 the week ending March 1st, it is the same for team  
13 members, yourself, Mrs. Bracewell, Miss Reaper and  
14 Miss Lyons; and during the week of March 2nd it  
15 appears Mrs. Halpenny is back on your team, and  
16 Mrs. Bracewell leaves to join Karen Power's team,  
17 do I have that correctly?

18 A. That is correctly.  
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Q. And for the period March 2nd through until March 23rd, 1981 did your team consist of those four women, namely, yourself, Ms. Halpenny again, Ms. Reaper and Ms. Lyons?

A. That's correct.

Q. So that for that three-week period you had three registered nurses and one registered nursing assistant as your team members?

A. Including myself.

Q. Including yourself, thank you very much.

You have told us as best you can recall it, Ms. Bell, what your general duties were as a team leader during this nine-month period. Was there at that time a job description in place for a team leader at The Hospital for Sick Children?

A. Yes, there was.

Q. I'm showing to you what I understand to be that job description that applied during that nine-month period. It is dated on the third to last page, November 8, 1968. But can you tell me, is this the job description that applied for the position of team leader during this period?

A. Yes, it was.

MS. CRONK: Thank you. May that be







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the next exhibit, sir?

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THE COMMISSIONER: 342.

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--- EXHIBIT NO. 342: Job description of team  
leader for The Hospital  
for Sick Children.

5

6

MS. CRONK: Q. Ms. Bell, I am  
interested in a number of the provisions of the job  
description, if we could look at them very briefly.

7

8

A. All right.

9

10

Q. As I read the description, the  
first and primary objective statement is "To Perform  
as a Nursing Team Leader".

11

12

Do you see that.

13

14

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19

A. Yes, I do.

Q. And then if we move to page 2  
it appears that there is some clarification as to  
what is meant by that and some specific objectives  
are set out to assist the candidate to meet her  
responsibilities as team leader. I would refer you  
to what is stated to be a specific objective in the  
middle of the page:

20

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"1. To know the implication of the  
diagnosis in terms of nursing care for  
each patient."

Do you see that?

A. Yes.





B.3

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Q. It's on page 2.

3

A. Yes.

4

5

Q. And that was part of the stated objectives for a team leader in the Hospital?

6

A. Yes, it was.

7

8

Q. And that included for your own position?

9

A. Yes.

10

11

12

13

Q. Was it part of a team leader's responsibility as you understood it, Ms. Bell, in light of this job description to know the clinical condition of each child on her ward when she was on duty?

14

A. Yes.

15

16

Q. Did that include both familiarity with the diagnosis and prognosis for each patient?

17

A. Yes.

18

19

20

21

Q. To do that I suppose a team leader would have to have enough clinical knowledge to recognize the implications of the diagnosis and the implications of the prognosis at least in terms of nursing care?

22

A. Yes.

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Q. Would you agree with that?







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A. Yes, I do.

Q. Was it your responsibility, for example, as a team leader on any given shift to know which patients were regarded by the medical staff as being in the most critical condition?

A. Yes, I would know; should know.

Q. All right. And when you came on as a team leader on duty, be it on a day shift or a night shift, was it part of your responsibility to find that out at the beginning of the shift?

A. Yes, it was.

Q. And when you should determine which patients were those considered to be most seriously ill, was it part of your responsibility as a team leader to monitor those patients closely throughout the balance of your shift?

A. Yes.

Q. And would you as well, once you had determined the identity of those who were on the seriously ill list, if I could put it that way, inform the other members of your team as to the identity of which patients were to be most closely observed during the shift?

A. Yes.

Q. If for example when you came on





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duty on 4B, you having determined which patients were most seriously ill on your own ward, would you as well then formally or informally be informed as to those patients who were most seriously ill on Ward 4A?

A. Informally, yes.

Q. And how would that happen normally?

A. After our report the team leader of 4A would inform me of who her concerns were for.

Q. All right. Would you similarly inform her of the patients about whom you had the most concern that night or that day?

A. Yes.

Q. If you came on for night duty as opposed to day duty for the moment, would you as well have available to you what has been described here as the seriously ill list prepared by the head nurse during the day shift?

A. I wouldn't have it in my hands, the supervisor would have it.

Q. Would you see it when you came on duty?

A. When the supervisor came around then I would see it again and review the list with her.





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Q All right. So if then the head nurse prepared that list during the day, I take it it was prepared for the purposes of assisting the night supervisors?

A The evening and the night supervisors.

Q Was a copy of it left on the ward?

A No.

Q So that you wouldn't see it then until the evening or the night supervisor actually attended on the ward?

A That is correct.

Q If a patient's condition changed during the shift such that he or she was no longer to be considered as critically ill as originally had been thought or conversely the patient condition deteriorated, did you as a team leader have the authority to make alterations in that seriously ill list so that the evening and night supervisors were kept informed of changing conditions?

A I would inform the supervisors that there was a change.

Q All right. And was it part of your responsibility to determine as the shift







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progressed whether or not a patient's condition was deteriorating?

A. Yes.

Q Or similarly whether a patient's condition was improving?

A. Yes.

Q To the best of your knowledge, Ms. Bell, was there one seriously ill sheet for both Wards 4A and 4B or was there a separate one maintained by each of the head nurses on 4A/4B?

A. There was a separate one maintained for each.

Q All right. The second specific objective set out on page 2 of the job description is described as:

"2. To make purposeful rounds on all team patients."

Do you see that?

A. Yes.

Q All right. Was it a team leader's obligation to make specifically rounds at set times during the course of any shift?

A. As soon as report was over we would make a round definitely and then our own discussion throughout the night, there wouldn't be exactly set times.





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Q As a general matter, would you  
as a team leader, if you came on duty for example  
at night, make rounds as soon as report was completed?

A Yes, I would.

Q And would you throughout the  
evening make rounds in a complete sense observing all  
the patients on your ward several times during the  
course of the shift?

A Yes, I would.

Q All right. When you did make  
rounds the first time, that is, after report was  
completed, would you do it alone or would you in the  
normal course be accompanied by other members of your  
team?

A On nights I would do it alone  
and discuss anything, if the nurse was in the room,  
discuss anything with her if there was a problem or  
if I had any concerns.

Q And then later in the evening  
when you were on night duty when you made rounds for  
the second and third time again, would you do that  
yourself or would you be accompanied by other members  
of your team?

A Again, I would do it myself.

Q Did you as the team leader on







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4B participate in rounds that were done by the team leader on 4A?

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A. No, I wouldn't.

5

6

Q. All right. The third specific objective that was set out on page 2 of the job description is described as:

7

8

"3. To obtain a meaningful report from previous team leader."

9

10

I take it that is the report that you spoke of just a moment ago?

11

A. Yes, it is.

12

13

14

15

16

Q. We have heard something about that, Ms. Bell. It is my understanding, please correct me if I'm wrong, that when you came on for duty again using the night shift for an example, the very first thing that happened is, you took report from the nurses going off from the day shift?

17

A. That is correct.

18

19

Q. And was there a particular individual who gave you report?

20

A. The team leader from days.

21

22

Q. All right. And what was the nature of the report, what was its purpose?

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A. It was to go for all the patients and it would indicate their condition - well,





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it would indicate their diagnosis, their condition, what tests they had had during the day or if they had had surgery or if they had returned from the unit or any kind of concerns that the team leader from days would have or things to watch for.

Q All right. And how long did it take generally for you to receive report coming on duty on a night shift?

A Depending on the number of patients, anywhere from 20 minutes to 40 minutes.

Q Was there anyone else present when you were taking report other than yourself and the team leader who was going off duty?

A Myself and my team members.

Q Was it required that your team members attend report when they came on duty at night?

A Yes, it was.

Q If one of your team members had been assigned by the head nurse during the day to constant nursing care duties that evening, would she participate in the report when she came on duty on the night shift?

A No, she would not, she would go directly to the room and get report from the nurse that was doing the constant nursing care on days.





B.11

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2

3

4

Q So that then would be an exception to the general rule that all the members of your team took report with you?

5

A Yes.

6

Q Is there any other exception that you can now recall?

7

A No.

8

9

10

11

12

Q And what happened at the other end of the shift when you were going off duty, was it part of your responsibility then to give a report to the team leader who was coming on duty during the day?

13

A That is correct.

14

15

Q And were members of your team obliged to be with you when that report was given or is that something you did alone?

16

A That is what I would do alone.

17

18

19

20

21

22

23

24

25

Q As a general matter, and we have heard about the hours that applied to the night shift and it has been suggested that it started at 7:15 p.m. in the evening and concluded at 7:15 a.m. the next morning, as a general matter if a nurse was on constant care duties, for example, would she remain in a patient's room until she was relieved by the day nurse coming on duty?







B.12

1

2

A. That is right.

3

Q. Was she required to do so?

4

A. Yes.

5

Q. So that if that day nurse came

6

on at 7:15 or was a little bit late she would be there until that nurse attended?

7

A. That is correct.

8

Q. The next objective that is set

9

out in the job description which I have some interest in, Ms. Bell, is described as:

10

11

"To understand and assess the

12

capabilities of the team members."

13

Do I have it correctly that what that

14

really involves is a familiarity by the team leader

15

with the nursing capabilities of the various nurses

16

and registered nursing assistants that were serving

on your team?

17

A. That is correct.

18

Q. Was it for example your

19

responsibility as a team leader to undertake

20

evaluations or assessments in a formal way of your

team members?

21

A. I would have input into the

22

evaluation, so, Mary and I would go over my team

23

members and then we would discuss any problems or any

24

25





B.13

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2

good points of the team members.

3

Q All right. By Mary, you mean

4

Mary Costello?

5

A Mary Costello, that's right.

6

Q So, I take it then that the

7

head nurse was responsible for actually completing the  
evaluation but you would participate in that process?

8

A That is correct.

9

Q All right. One of the specific

10

objectives that is set out under that general goal,

11

Ms. Bell, Item No. 3 is: "To make individual

12

assignments". Can you help me please as to what that  
means?

13

A Well, have input into the level

14

of care that my team members were at and inform Mary  
of their capabilities or if they needed more experience

15

16

in one area or they would like more experience in one

17

area then either do the assignment myself if that was

18

my job at the time, like, on weekends or during the

19

week, let Mary Costello know that when she is making

20

up the assignment to perhaps change the type of  
assignment.

21

22

23

24

25







C/EMT/ak

1

2

Q. All right.

3

4

We have heard before from Miss Costello who I am sure you are aware gave evidence last week before the Commissioner that during the course of her normal day part of her responsibility was to actually complete the assignments and to assign specific nurses to specific patients for the forthcoming night shift. All right.

5

6

7

8

9

10

Now, when you came on duty at night did you have authority to change those assignments if you felt it appropriate?

11

12

A. Yes.

13

14

15

16

Q. All right. And when, for example, when you came on duty on the night shift would you ascertain which nurses had been assigned to which patient?

17

18

19

20

21

22

23

A. I would generally have listened to the report and assessed the type of patient that we had and go over the assignments, but at times if there was a concern about a patient assignment, the team leader that was giving the report would be already aware of this and we would go over the assignment together sometimes even before we got started.

24

25

Q. I see. Did that happen with





1  
2 some regularity that the assignments were changed?

3 A. It would happen as the need  
4 arose.

5 Q. Could I ask you if you would,  
6 please, to turn to page 3 of the job description.  
7 There are a great number of objectives set out  
8 generally in the job description, Miss Bell, but  
9 on page 3, the third main objective is set out -  
10 I'm sorry, it is page 5.

11 At the bottom of the page the third  
12 main objective is set out and it is described as  
13 "To perform as a team member complex functions  
14 requiring mature judgment and technical skill".  
15 And then to clarify what is I take it meant by  
16 that objective there are then a number of specific  
17 objectives set out on page 6 and the second one is  
18 of interest to me.

19 It says "To care for patients whose  
20 health is critical or life threatening".

21 Now as I understand it this job  
22 description applied solely to team leaders; do I  
23 have that correctly?

24 A. Yes.

25 Q. All right. Was it then the  
responsibility of a team leader to have particular





1  
2 responsibility for those patients who were considered  
3 to be most critical or most ill on the ward at any  
4 given time?

5 A. Another nurse could be assigned  
6 to these with as much experience or perhaps more, but  
7 the team leader would help in assessing the patient  
8 or if there was any care that needed to be given  
9 she would help the nurse that was giving it.

10 Q. Well, did it regularly happen,  
11 Ms. Bell, on your own ward, on Ward 4B, that team  
12 leaders, be it on a day shift or night shift, were  
13 assigned specific responsibilities for a particular  
14 patient?

15 A. We would give medications for  
16 RNAs.

17 Q. All right. Apart from that?

18 THE COMMISSIONER: I'm sorry, you  
19 were given?

20 THE WITNESS: Medications for RNAs.

21 THE COMMISSIONER: Oh, yes.

22 MS. CRONK: Q. Apart from giving  
23 medications for registered nursing assistants, did  
24 you as well frequently have responsibility for  
25 particular patient assignments yourself?

A. Sometimes I would.







1  
2  
3 Q. All right. And where that  
4 did happen to you, for example, as team leader or,  
5 for example, to the team leader on 4A, was it required  
6 or intended that the most seriously ill patients  
7 would be assigned to you?

8 A. If I was doing the job as  
9 team leader I would not take the most seriously  
10 ill child as a patient as well.

11 Q. That would be assigned I take  
12 it to another member of your team?

13 A. That is correct.

14 Q. All right. And as a normal  
15 matter from your prospect as the Ward 4B team  
16 leader would you assign the most seriously ill  
17 patients to your most experienced nurses?

18 A. Generally I would.

19 Q. Would that exclude registered  
20 nursing assistants?

21 A. Yes.

22 Q. To the best of your knowledge was  
23 that the practice on 4A as well?

24 A. Yes.

25 Q. And as a general rule - we  
have lost our chart, Ms. Bell, that was here last  
week showing the layout of the two wards. Perhaps





1  
2 I could get that back, Mr. Registrar.

3 THE COMMISSIONER: I take it that  
4 masterpiece of Mr. Hunt is not going to become an  
5 exhibit.

6 MS. CRONK: Mr. Hunt can speak for  
7 his artistry, sir.

8 THE COMMISSIONER: Well, perhaps  
9 we didn't number it. That is that one up there on  
10 the board. I don't see it marked.

11 THE REGISTRAR: It is not marked.

12 MR. HUNT: We are talking about the  
13 layout, are we?

14 MS. CRONK: No, Mr. Hunt, we are  
15 talking about your artistry here.

16 MR. HUNT: No, I didn't make that  
17 an exhibit.

18 THE COMMISSIONER: No.

19 MS. CRONK: I think the question  
20 is whether you would like it as an exhibit.

21 MR. HUNT: Someone has just  
22 written on it.

23 MS. CRONK: I just did.

24 THE COMMISSIONER: Yes.

25 MS. CRONK: I would have no  
objection.





1

2

THE COMMISSIONER: Well, all right.

3

The summary for Sui Scott was made Exhibit 340.

4

That was yours, was it not?

5

MS. CRONK: Yes, sir.

6

THE COMMISSIONER: That is not

7

your summary for Sui Scott as well too? No, that  
was made an exhibit and was put --

8

MS. CRONK: That is a separate

9

exhibit, sir.

10

Mr. Hunt is quite correct; I did

11

write on his exhibit.

12

THE COMMISSIONER: Well, all right.

13

Let's make it 343.

14

--- EXHIBIT NO. 343: Calculations prepared by  
Mr. Hunt showing attendance  
of Nurses Trayner and Nelles.

15

16

MS. CRONK: Thank you, sir.

17

18

Q. Ms. Bell, I'm sorry, we

19

were talking about the assignment of the more  
experienced nurses to those patients who were

20

most seriously ill on any given shift. We have

21

heard in prior evidence that Room 431 on Ward 4B

22

was an infant room.

23

A. That is correct.

24

25







1

2

3

Q. And Room 418 on Ward 4A was  
an infant room?

4

A. That is right.

5

6

7

Q. And as a general matter on  
Ward 4B were your most experienced nurses on your  
team assigned to Room 431?

8

A. Yes.

9

10

Q. To the best of your knowledge  
did that apply to Room 418 on Ward 4A?

11

A. Yes.

12

13

Q. Did that follow by virtue  
of the fact that the most seriously ill infants  
were placed in those rooms?

14

A. That is correct.

15

16

Q. We have heard something as  
well about isolation rooms, single patient rooms  
that existed on Ward 4B and 4A.

17

18

I take it that a very seriously  
patient could be placed in isolation as well?

19

A. Yes.

20

21

22

Q. And in that situation again  
would you look for the most experienced nurse on  
your team to be assigned to that patient?

23

A. Yes.

24

25

Q. Did that as a general matter





1

2

as far as you are aware apply on 4A as well?

3

A. Yes.

4

Q. Would that apply as well,

5

Ms. Bell, to constant nursing care duties?

6

A. Yes.

7

Q. Again you would look for your

8

most experienced nurse who was working on that

9

particular shift to assume those responsibilities?

10

A. Yes. But we would also try

11

and give the opportunity to a not so experienced

12

person too to get some experience, and that and just

13

be supervising more closely.

14

Q. If that happened, if a less

15

experienced nurse was assigned to constant nursing

16

care duties, did she work directly under the super-

17

vision of a registered nurse on the team?

18

A. Yes.

19

Q. Were they both required then

20

to be in the patient's room consistently?

21

A. No.

22

Q. Just the registered nursing

23

assistant who had been assigned --

24

A. No, I didn't mean a registered

25

nursing assistant. I mean a registered nurse who

didn't have as much experience.





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Q. I am sorry. Were registered nursing assistants ever assigned constant nursing care duties on Wards 4A or 4B?

A. No.

Q. That was the function of registered nurses?

A. Yes.

Q. All right. I am interested as well, Ms. Bell, generally in your responsibilities on a night shift as team leader.

You have told us, for example, that when you reported for work the very first thing you did was to take report.

A. Yes.

Q. And that could last, you told us, anywhere from 20 to 40 minutes and involved the other members of your team?

A. That is correct.

Q. All right. What would you then do on the night shift after you completed the report?

A. Well, we would count the narcotics.

Q. All right. How long would that take?







1

2

A. Two to three minutes.

3

4

Q. Was that the responsibility  
of the team leader?

5

A. Yes, it was.

6

7

Q. Could you in certain circum-  
stances delegate that to another registered nurse?

8

A. Yes, I could.

9

10

Q. Did that happen?

A. Very seldom it did.

11

12

Q. I'm sorry?

A. Very seldom it did.

13

14

Q. All right. And after you  
had taken the narcotic count what in the course of  
a normal night's duties would you then do?

15

16

17

18

19

20

21

22

A. After that I would go around  
and make rounds and I would check the patients -  
well, the patient assignment I would check first  
and then I would make rounds on the patients  
checking their condition and just going over what  
had been said in reports. Then I would probably -  
we had a patient classification sheet that we would  
do and we would have to have it done by a certain  
time which was called NARvel.

23

Q. NARvel?

24

25

A. Yes. And if I had a patient





1  
2 assignment of course I would look after my patients.

3 Q. All right.

4 A. If there was any problems or  
5 if certain things had to be done then I would do  
6 that as far as helping other nurses.

7 Q. All right. Could I stop you  
8 there just for a moment then?

9 A. Sure.

10 Q. After you completed the  
11 narcotic count and we are talking again about a  
12 night shift.

13 A. Yes.

14 Q. A regular night shift.

15 A. Yes.

16 Q. You then, as I understand  
17 what you have just said, review the patient assign-  
18 ments on the assignment books to determine which  
19 nurse had been assigned to which patients?

20 A. Yes.

21 Q. And you would then do your  
22 rounds?

23 A. Yes.

24 Q. And how long as a general  
25 matter would it take you to do your rounds at the  
start of a shift?





1

2

3

A. Depending on the activity  
of the ward it could take up to an hour.

4

5

6

Q. All right. And after you  
had completed your rounds, was it then that you  
turned to the completion of the NARvel sheets?

7

8

9

10

A. Yes.

11

12

13

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16

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25

Q. And would that kind of  
function involving I assume the paperwork that  
it does be completed at the nursing station?

A. Yes, it would.

Q. All right. As a general  
matter then when would you turn to the paperwork  
that is involved in your responsibilities?

-----







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A. It would be in between actual patient care, that patient care had to be done and I would do that first. Or if there was medications that had to be given I would give the medications for the RNA's, or if there was any medications I had to give to my own patients I would do that. Our digoxins were given at 9 o'clock along with our diuretics, and you would do that, or I would check the digoxins with the other RN's.

Q. Was it part of your responsibility then, Ms. Bell, at the start of each shift to review what medications had in fact been ordered by physicians and to review the times when they were to be given?

A. There wasn't enough time at the beginning of the shift to go and do that, no.

Q. You have said for example that the digoxins on your ward were given at 9 o'clock at night along with the diuretics?

A. Yes.

Q. Would you before those medications were given have checked the doctors' orders, or did you have any role to play in ensuring that those medications were given when they were supposed to be?





D.2

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2

A. I would check them.

3

4

5

Q. And that I take it would have to be done before 9 o'clock at night, because that is when the diuretics and the digoxin were to be given?

6

A. Yes.

7

8

Q. And you say you would check them, what did that involve?

9

10

11

12

A. We had our nursing care plan that was on the chart and the medications were listed on the nursing care plan. Then you would go over the doctor's order just to check that the dosages were correct and that there were not changes made.

13

14

Q. Would you do that for all medications that had been prescribed or ordered to be administered that night?

15

16

17

A. I would do it for the medications that I was giving, and it would be the responsibility of the RN to do that for her patients.

18

19

20

Q. And do I have it correctly then that as team leader you were not required to review generally all the medications that had been ordered to be given on a particular shift?

21

22

A. Not at that point, I would go over them later on.

23

24

25

Q. When would you do that?





D.3

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A. Any time later that night.

Q. By the time that you completed your report, completed the narcotic count, and completed your rounds, in general terms can you help me as to what time that would be in the evening?

A. I could start going over them as early as 10 o'clock at night.

Q. Would that be the earliest time as well as a general matter that you would turn to the patient classification sheets?

A. Yes.

Q. So would I have it correctly then that the first time that you would as team leader be at the nursing station for the purposes of completing the NARvel sheets or reviewing medications would be approximately 10 o'clock at night?

A. Yes.

Q. And prior to that, an hour prior to that we know that there were certain drugs that had to be given; if you had not been assigned yourself a particular patient or patients that evening, would you have any involvement at all in the giving of those medications at 9 o'clock?

A. Generally I would check the digoxin dosages with the other RN's.







D.4

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Q. Was it the rule or the practice on Ward 4B that a registered nurse who was giving digoxin at 9 o'clock at night seek you the team leader, out to have that dose checked?

A. Not necessarily but it was easier.

Q. Could it also happen that if there were more than one registered nurse on duty that evening, other than yourself, that she could seek out another registered nurse to check the dosage?

A. Yes, she could.

Q. If you were not involved in the checking of the doses of digoxin at 9 o'clock when they were to be given, when in general terms did you then sit down and review the medications that were to be given throughout the balance of the shift?

A. I could start as early as 9 o'clock.

THE COMMISSIONER: I am sorry?

MS. CRONK: As early as 9 o'clock.

THE COMMISSIONER: I missed what happened before, was that what she said.

MS. CRONK: I think that is what Ms. Bell said, as early as 9 o'clock.

THE WITNESS: Yes.





D.5

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MS. CRONK: Q. Now, in addition to the completion of the NARvel sheets, the patient classification sheets, I take it you were required to do those on each shift be it day or night?

A. We would do one initially on nights, that would be fed into the computer.

Q. And that was your responsibility as team leader?

A. Yes.

Q. And that was done at the nursing station?

A. Yes.

Q. Did you on the night shift have access to the offices of either Mrs. Radojewski or Ms. Costello?

A. No.

Q. Were they locked or unlocked during the night shift?

A. I really couldn't tell you, I don't know.

Q. Was it part of your authority, if you will, that you could if you wished use those offices at night, were you free to do so?

A. No, I don't think so.

Q. Do I have it then that any





D.6

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paperwork that you were required to complete during the night shift would be completed at the nursing station?

5

A. Yes.

6

7

8

Q. Other than the NARvel sheets, were there any other forms of documentation that you were required as a team leader to complete during the course of the night shift?

9

10

11

12

A. There was patient census sheets; there was the diet sheets as well; and there was checking of the charts for any changes; and of the medication tickets as well.

13

14

15

Q. Could you do that kind of work at any time throughout the shift, or were there particular times when you tried to accomplish that?

16

17

18

19

A. The charts could be done any time throughout the shift. The census sheets and the diet sheets have to be done by a certain time.

20

21

22

23

24

25

Q. What was the time by which they had to be completed?

A. Five or six.

Q. In the morning?

A. Yes.

Q. Did you as well as part of your duties at night have responsibility for assigning







D.7

1

2

relief nurses to the nurses who were performing

3

constant nursing care duty?

4

A. Yes.

5

Q. Can you tell me please was that

6

recorded in any way?

7

A. We would generally mark that

8

relief was required, and we would either rub out the

9

word "relief" and put in the nurse's name, or we would  
just put the nurse's name beside the word "relief".

10

Q. When you say you would write

11

that down are you referring now to the assignment books?

12

A. Yes.

13

Q. So that on any particular night

14

if a patient had been assigned to constant nursing

15

care duties should there then be two names, the names

16

of two members of the nursing staff beside that

17

patient's name, the one who had the nursing care

18

responsibilities plus the name of the nurse who was  
to relieve her?

19

A. They were in different slots

20

on the page, we had an area for the night nurses and

21

an area for the day nurses.

22

Q. Just dealing with the night

23

shift; if a particular patient was on constant nursing

24

care with a particular nurse, was the name of the

25





D.8

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2

relief nurse set out as well in the assignment book?

3

A. Yes.

4

Q. And that was your practice on

5

Ward 4B?

6

A. Yes.

7

Q. To the best of your knowledge

was that the practice on Ward 4A?

8

A. Yes.

9

THE COMMISSIONER: These are on the

10

assignment book, is that right?

11

THE WITNESS: Yes.

12

MS. CRONK: Q. Perhaps you can help

13

me with that, Ms. Bell, before we go any further. We

14

know that Justin Cook, the patient who died in the

15

Hospital on the morning of March 22nd, 1981, was  
under constant nursing care the night that he died.

16

This is the Ward 4B assignment book for the night

17

shift on March 21st, I'm sorry, Ward 4A.

18

THE COMMISSIONER: What number is that?

19

MS. CRONK: I am sorry, sir, that is

20

Exhibit 32A, Mr. Commissioner, Tab 13, the 4A

21

Assignment Book.

22

Q. Ms. Bell, this is the Ward 4A

23

assignment book and the entries under the long night  
shift of March 21st, 1981 --

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D.9

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THE COMMISSIONER: What page is this again?

MS. CRONK: Page 178-179, Mr. Commissioner.

THE COMMISSIONER: Tab 13.

MS. CRONK: Tab 13.

THE COMMISSIONER: Thank you.

MS. CRONK: Q. We see that on that particular night Ms. Nelles was assigned to Justin Cook in Room 418, and we have heard previously that he was on constant nursing care that evening. Do you see there any indication of the nurse who was to relieve Ms. Nelles when she took her breaks that night?

A. No, there isn't.

Q. But it is your understanding that the normal practice on the wards was to keep a record in the assignment books of those nurses who were serving relief?

A. I meant relief by relieving as far as taking the patient care, I think we are talking about two different things.

THE COMMISSIONER: I am sorry, Miss Cronk, I am having great difficulty in understanding the evidence. I think if you could help us by repeating some of this. I don't know what the







D.10

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2

problem is, Miss Bell, but perhaps you are speaking too low; perhaps you are speaking not distinctly enough; perhaps I am too old, it could be one of those three.

5

6

THE WITNESS: I will try and speak up, sir.

7

8

THE COMMISSIONER: You can't do much about the last.

9

10

MS. CRONK: Perhaps if you could lean forward a bit, I am not sure I can help you any more with it.

11

12

13

14

Q. I am a little bit confused on this aspect of it, Ms. Bell, and may we go back? If a particular nurse was assigned to constant nursing care duties on any particular evening --

15

16

17

18

A. Yes.

19

20

21

Q. Night shift, I take it there were times during the course of the night shift when she would be permitted to take a break?

22

23

24

25

A. That is correct.

Q. Whether it is for coffee, lunch or dinner?

A. That is correct.

Q. Was there then a particular nurse who was to relieve her when she took her breaks?





D.11

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2

A. No, there wasn't.

3

4

5

6

7

8

9

A. Yes, it was.

10

11

Q. Was it your responsibility to do that, or was it not?

12

A. Yes, it was.

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Q. Do I have it then that there were particular nurses who were assigned to relieve constant nursing care nurses on a night shift?

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A. It wasn't written down, but the team leader would be aware that the nurse, and the nurse that was doing the constant nursing care they would arrange something between the two of them, whether it would be the team leader that actually does the relieving or whether it would be somebody else depending on their assignment.

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Q. Well, let's take a hypothetical situation if we could and let's restrict it to Ward 4B.

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A. Okay.





D.12

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Q If you came in on a particular night shift and there was one patient on 4B who was on constant care, there was I take it a specific registered nurse who was assigned to perform those duties?

A. That is correct.

Q Would she before taking her coffee break, her first coffee break that night, need to speak to you as to who was to relieve her?

A. Yes.

Q Did she seek that information out at the beginning of the shift, was it predetermined at the beginning of the shift, or would she simply call for you from the patient's room when she wished to take her coffee break?

A. On nights she would generally call from the patient's room.

Q I take it then that it was not part of your normal routine at the beginning of any night shift to address your mind to which nurses were to relieve constant nursing care nurses?

A. No.

Q As it came up during the course of the night that would be attended to?

A. Yes.







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Q Was it required that if a nurse who was performing constant nursing care duties to speak to you before she left that patient's room?

A For any amount of time, but if she just had to step out to go to the bathroom she could get somebody else to go in for her.

Q If she went for example on her lunch or dinner break during the course of the evening was she required to speak to you before she left that patient's room?

A She was not required to, but she would.

Q As a matter of practice that normally happens?

A Yes.

Q Did that happen as well with coffee breaks?

A Yes.

Q So far as you are aware does the same system apply on Ward 4A?

A Yes.

Q When you spoke a few moments --

THE COMMISSIONER: Let's make absolutely sure, constant nursing care is that the child could not be left alone?





D.14

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THE WITNESS: That is correct.

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THE COMMISSIONER: That was absolutely  
mandatory was it, absolutely vital?

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THE WITNESS: Yes.

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THE COMMISSIONER: So that the nurse  
could not leave for any purpose without having  
someone replace her?

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THE WITNESS: That is correct.

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THE COMMISSIONER: And if a nurse  
having constant nursing care wanted to go on any kind  
of a break at all she would have to either get somebody  
or arrange with you to get somebody?

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THE WITNESS: That is right.

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THE COMMISSIONER: If she did arrange  
with you did that generally mean that you did it, or  
does it mean that you designate someone else, or what?  
I really want to know whether it was informal or formal?

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THE WITNESS: It was informal.

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THE COMMISSIONER: Most of the time  
what did happen, did the nurses just arrange it them-  
selves; did you arrange it; or what happened?

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THE WITNESS: Most of the time if it  
was a long break the team leader would go in and  
actually do the relieving because the other nurses  
just didn't have the time to do that.





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MS. CRONK: Q Did that apply to  
Ward 4A as well?

A. Yes.

Q I take it then that there was  
no formal record in written form kept of which nurses  
were relieving other nurses on any given night shift?

A. There was no formal record, no.

Q When you referred to a notation  
being made in the assignment book to relieving, were  
you referring to nurses who were posted as relief for  
part or an entire shift to another ward?

A. That is right.

Q No relationship to relieving  
for constant care nursing?

A. No, I am sorry.

Q You have told us as well that  
as part of your responsibilities during the course  
of the evening on the night shift you would check  
medications that had been ordered by the physicians  
for particular patients, did you do so as well at  
the end of the shift before going off duty?

A. No.

Q Was there anyone during the  
course of the night shift amongst the members of your  
team who was assigned responsibility for ensuring







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that the medications that had been ordered to be given  
were in fact given?

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A. No.

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Q. And we have heard from other  
witnesses, and I would ask you to confirm, that the  
clinical pharmacist who was assigned to Wards 4A/4B  
in September of 1980, did not work the night shift?

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A. No, she did not, that is  
correct.

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Q. We have heard as well from other witnesses, Ms. Bell, and I would ask you to confirm this if it is indeed accurate to the best of your recollection, that once the cardiology unit had been moved from Ward 5A to Wards 4A/B the nursing staff was required to work two weeks of day shifts followed by two weeks of night shifts and alternating on that basis?

A. That is correct.

Q. Is that correct?

A. Yes.

Q. We have heard as well that there was an attempt made to pair one nursing team with the other. Was that true?

A. Yes, 4A and B.

Q. All right. Do I have it then that your team when it was working for example on the long night shift would normally be working with the same team on Ward 4A?

A. That is correct.

Q. And whose team was that?

A. Phyllis Trayner's team.

Q. And was that true throughout this entire nine month period?

A. Yes, it was.





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Q. Was that true as well during  
the days if your team was working the long day shift?

A. Yes, that is correct.

Q. Can you help us please, Ms.  
Bell, as well in your judgment based on your  
experience on those wards who would normally have  
access to Wards 4A/B at night?

A. Doctors would have access,  
cleaning staff, the person who picked up the NARvel.

THE COMMISSIONER: That picked up  
the laundry did you say?

THE WITNESS: The NARvel.

THE COMMISSIONER: Oh, the NARvel.

THE WITNESS: Yes. There would also  
be the person that picked up the laundry, maintenance.

MS. CRONK: I am sorry, maintenance?

A. Maintenance, yes.

Q. Yes.

THE COMMISSIONER: Did you say some-  
thing before maintenance?

THE WITNESS: Laundry.

THE COMMISSIONER: Laundry, all right.

THE WITNESS: Anybody from any other  
ward, any nurses or doctors or ward clerks.

MS. CRONK: Q. Did the ward clerks







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for Ward 4A/4B work nights?

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A. They worked part of the evening,

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so, they would be there for part of our shift, the  
beginning of our shift.

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Q. Did they normally work after

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11 o'clock at night?

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A. No.

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Q. All right. If a ward clerk

from another ward was observed on your wards after

11 o'clock at night, would that be regarded as

11

unusual?

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A. She could be just passing

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through. There were ward clerks that worked in  
other areas.

14

15

Q. Well, if she was passing

through at midnight or one in the morning, would that

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be regarded as unusual?

17

A. No.

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Q. I take it though if there was

19

an individual who was on the ward who was not known

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to the nursing staff, that individual if seen would

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be stopped and asked who they were and what they were  
doing there?

22

A. Not necessarily, no.

23

Q. So that if someone who could not

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be identified by the nursing staff who observed them  
was seen on the ward, they might be able to pass  
through the ward without being spoken to?

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A. They might.

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Q. Did the same degree of ready  
access to those wards apply to residents from other  
areas of the hospital who would be using the  
residents sleeping quarters on Ward 4A/4B?

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A. Yes, definitely.

10

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Q. Were there on occasion as well  
parents who were there at night?

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A. Some parents were there, yes.

13

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Q. We have heard that there was a  
particular room available on those two wards for  
parents to sleep over in situations of emergency with  
their children and, if so, I take it they could be  
there for the entire night shift?

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A. That's right, we had two parent  
rooms.

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Q. All right. Can you help me as  
to where the parent room was on 4B?

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A. The one we used was down that  
corridor where the play room is, it was further down  
the corridor.

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Q. All right.

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A. And the 4A one was at the far

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left at the end of the hall.

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Q. I take it that at the beginning

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of any given shift, or at least as the night shift

6

progressed, you as a team leader would know if any

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parents were remaining and staying the night?

8

A. Yes, that is correct.

9

Q. And if on occasion when there

10

were no parents sleeping over you noticed a parent on

11

the ward after midnight, I take it that you would make

12

note of that?

A. Yes.

13

Q. What were the normal visiting

14

hours on those wards?

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A. From 11:00 in the morning until

16

8:00.

Q. Eight in the evening?

17

A. Yes. Parents could be there

18

pretty well any time.

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Q. You have mentioned as well that

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the individuals who picked up the laundry would have

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access to the wards. Did that happen at a particular

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time on the night shift?

A. It probably did but I don't know

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of a particular time.

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Q. Was there more than one individual involved or was it the same individual?

A. I couldn't say.

Q. All right. Do you know when the cleaning staff were present on the wards at night?

A. No.

Q. All right. What about the person who picked up the NARvel sheets, when would they normally be on the ward?

A. They could come any time after midnight and sometimes they would return if we were busy and we didn't have the NARvel ready, they could come back.

Q. When in your experience on 4B generally did the individual come and pick up the NARvel sheets?

A. Usually around 3:00.

Q. And as well I take it that evening and night supervisors would have access to those wards?

A. That is correct.

Q. And night supervisors in fact made rounds on those wards throughout the course of the long night shift?

A. That's right.







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Q. Was there in your experience any particular time when the night supervisor might be expected to appear on Ward 4B for those rounds?

A. The evening supervisor could come after 9 o'clock or again at 11:00 just before she left. The night supervisor could come any time between 1:00 and 3:00.

Q. Is that generally before 3:00 in the morning when the night supervisor was there?

A. Generally it was.

THE COMMISSIONER: I don't understand. Are you talking about two or three trips or just one trip for the night supervisor?

THE WITNESS: They could make two trips.

MS. CRONK: Q. What did they normally do, Ms. Bell? Were they normally there for one set of rounds, were they normally there several times during the course of the night shift?

A. At least once.

Q. And on occasion it would be more than once?

A. Yes.

Q. Could they be there as a normal matter, were they often there more than once without





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any emergency having arisen?

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A. They could come back, yes.

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A. Yes.

Q. And with an evening supervisor,

that was normally either at 9 o'clock or 11 o'clock  
at night?

A. Yes.

Q. As you can recall it?

A. Yes.

Q. Now, in addition to the evening  
and night supervisors, on occasion would there as well  
be lab technicians, laboratory technicians who had  
access to those wards on the night shift?

A. Yes.

Q. If you saw a lab technician on  
the ward after midnight, would you regard that as  
unusual?

A. No.

Q. In your experience did that  
happen?

A. Yes.





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Q. Were there in your experience members of the IV team who were on those wards at night?

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A. Not at night, they could be there until 11 o'clock but not after 11:00 or 11:30.

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Q. Were there any other individuals other than those that you have outlined that you can now recall as having access to those wards at night?

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A. That's about all I can recall.

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Q. Do you recall, would the maintenance people be there on a normal basis or would they have to be called before they would attend on the wards?

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A. Generally they would have to be called.

Q. All right. And that would be done for the obvious reason if something required repair or something had broken down?

A. Yes.

Q. I am interested, Ms. Bell, as well in the interaction between the 4A and 4B nurses at night during the course of the night shift. If a 4B nurse assigned to a particular patient or patients on Ward 4B was working a night shift, would she have reason to be on the Ward 4A side of the ward in a







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non-arrest situation?

A. She could be.

Q. All right. For example, if on occasion 4B nurses were assigned to relief duty on 4A, clearly they would spend part or the entire shift on 4A?

A. That is correct.

Q. And that happened in reverse as well on occasion?

A. Yes, yes it did.

Q. Is it also correct that on occasion a 4B nurse would be asked to relieve if only for a moment or two a 4A nurse who wished to step out for a cigarette or to go to the washroom or to make a phone call?

A. It could happen, yes.

Q. And that could happen in reverse as well?

A. Yes, it could.

Q. Could it also happen that a 4B nurse would seek out a nurse on 4A simply to chat for a few moments?

A. Yes.

Q. And that happened in reverse?

A. Yes, it would.





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Q. Would it be fair of me to suggest, Ms. Bell, that during the course of a normal long night shift on those two wards that there really was ready access for all nurses on the wards to the other side of the ward?

A. Yes, there was.

Q. And that would be true whether it applied to team leaders, registered nursing assistants or to registered nurses?

A. Yes.

Q. Was it correct as well that the nursing station located on the middle of the two wards really served as a centre of focus, if you will, for the nurses who were not in a patient room attending to a particular patient?

A. That is correct.

Q. So that at any given time there might be a number of nurses at the nursing station?

A. Yes.

Q. Either having a coffee, reviewing a child's medical chart or completing paper work of one kind or another?

A. Yes.

Q. Am I correct further that there were also occasions when no one would be at the nursing





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station?

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A. That's right.

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Q. And that would apply as well to  
the team leader?

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A. Yes.

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Q. We have been told previously  
that an emergency resuscitation cart was kept on each  
of Wards 4A/4B, that there was a separate cart on each  
side of the ward. If a patient on either ward  
developed difficulties when as a general matter would  
the resuscitation cart be brought into the patient's  
room?

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A. If the need was there, if a  
child had actually either stopped breathing or the  
heart had stopped, we would bring in the resuscitation  
cart.

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Q. Did it frequently happen that  
the cart was brought in before a Code 25 was called?

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A. Yes, it could happen, yes.

19

Q. Did it also happen that the cart  
could be brought in before technically a Code 23 had  
been called?

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A. Not usually.

22

Q. Usually was a Code 23 for a  
specific doctor then called before the cart would be

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brought into the room?

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A. Yes.

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Q. Was there any rule that required the 4B cart to be brought into a 4B patient's room if a 4B patient was in difficulty or could the 4A cart be used?

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A. The 4A cart was kept half way down the 4A hall, it would be much easier to bring in the 4B cart that's why it was located on that side.

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Q. So, as a practical matter the cart for the particular side of the ward involved was used for the patients on that ward?

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A. That is correct.

Q. Are you familiar with the contents of the crash carts on those two wards during this nine month period, Ms. Bell?

A. I think so.

Q. All right. In your experience, did you ever see digoxin on the crash cart kept on either of the two wards?

A. No.

Q. All right. Were there rules that applied on the wards, Ms. Bell, with respect to the stocking of the crash carts?

A. There was no rule, no, as long as







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it would be re-stocked immediately after the stock was depleted and the top of the crash cart was replaced.

Q. Well, for example, at the beginning of a night shift when you came on duty, was it part of your responsibility to check the Ward 4B crash cart to ensure that it had been fully stocked?

A. It was either my responsibility or to delegate it to someone else, yes.

Q. That was done at the beginning of every night shift?

A. Not necessarily, no. It could be done half way through the shift or perhaps even as late as 6:00 in the morning.

Q. But at some point during the evening if you yourself had not done it you would request one of your team members to check the crash cart?

A. Yes, I would.

Q. And that would be in a situation I take it where the crash cart hadn't been used?

A. That's right.

Q. And if the crash cart had been used in a patient's room during the night shift was it the responsibility of either yourself or any of your team members to ensure that it was re-stocked before





1  
2 you left the ward that night?

3 A. Yes.

4 Q. And would you normally do that  
5 yourself or was that something you could delegate?

6 A. I could delegate that as well.

7 Q. Were there set times during the  
8 12 hour night shift when that cart was to be checked?

9 A. There were no set times as long  
10 as it was checked some time during the night shift.

11 Q. And if it had been used during  
12 an arrest, would you as the team leader if you were on  
13 duty ensure that it had been checked before you left  
14 that morning?

15 A. No.

16 Q. Was it your responsibility to  
17 ensure that someone else had checked it?

18 A. No.

19 Q. I take it then, or perhaps you  
20 can tell me, were there situations when the cart after  
21 having been used during an arrest was not re-stocked  
22 on the same shift, or do you know?

23 A. Was there instances - I am sorry,  
24 could you repeat that?

25 Q. Yes. Was there an occasion of  
which you are aware where the cart having been used





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during an arrest was not re-stocked after the arrest on the same shift?

A. I know of an occasion, yes.

Q. All right. I take it that was not the normal practice?

A. No, it was not.

Q. And that wasn't encouraged?

A. No, it was not.

Q. Normally it was to be re-stocked as soon as its use had been completed and during that arrest procedure?

A. Yes.

Q. We've heard something as well about the types of syringes and other equipment which were available for use on Wards 4A/4B. I take it you are familiar with those as well?

A. Yes.

Q. I would like to review them with you briefly. First, it has been suggested by a number of witnesses that there was a tuberculin sized syringe which held up to 1 cc of medication and that was readily available for use on Wards 4A/4B. Do I have that correctly?

A. Yes, that is correct.

Q. Other than the 1 cc syringe or







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the tuberculin syringe, what was the next largest  
size of syringe that was available for use?

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A. 3 cc.

5

Q. And when would that normally be  
used?

6

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A. If we needed something that we  
would have to draw up more than 1 cc, 1 to 3 cc.

8

9

Q. What was the next largest size  
of syringe commonly available on the wards?

10

A. 6 cc.

11

Q. And the next?

12

A. 12.

13

Q. Was there as well a 10 cc  
syringe or no?

14

A. No, I don't think there is.

15

Q. Was there a syringe larger than  
a 12 cc syringe in use on those wards?

17

A. Yes, there is a 20 cc.

18

Q. And the next largest?

19

A. 30.

20

Q. I think I know the answer to the  
next question.

21

A. 60.

22

Q. 60?

23

A. Yes.

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Q. A 60 cc syringe I suggest is  
very large indeed?

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A. Yes, it is very large.

5

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Q. What was the purpose for having  
a 60 cc syringe available on those wards?

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A. The only time that I have seen  
it used on Ward 4B was if we were infusing on a sage  
pump, an IV solution, and that was to infuse, like, a  
small amount of fluids.

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Q. All right. Well, you are going  
to have to help us with that a bit more, Ms. Bell.  
When you are infusing on an IV with a sage pump, how  
would the syringe be involved?

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A. It is the syringe that you use  
that sits on the sage pump and what it does is it  
pushes the plunger at a set rate of how much fluid  
you want to infuse per hour.

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Q. All right. Was a 60 cc syringe  
ever used for the purposes of administering medications  
on either of these wards?

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A. No.

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Q. If a 60 cc. syringe was observed in the possession of a nurse or Registered Nursing Assistant on the ward and not in use with a Sage pump, would that be regarded as unusual?

A. Yes.

Q. What about a 30 cc. syringe? Were there circumstances when a syringe that large was used to administer medication?

A. For medications, yes.

Q. I'm sorry, it was used?

A. It wasn't used.

Q. It was not used. What was a 30 cc. syringe normally used for?

A. Well, either a 30 actually or a 60 cc. syringe could be used for just drawing up formula to make sure you had an accurate amount.

Q. Was there any other use for a 30 cc.. syringe?

A. Not that I can think of, no.

Q. Was a 20 cc. syringe normally used for the administering of medication?

A. No.

Q. If digoxin was to be given orally as we have heard was often the case at nine o'clock to a particular patient, what size syringe





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would normally be used to give it orally by dropping  
it into the patient's mouth?

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A. Generally it would be the TB  
syringe.

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Q. That would be the 1 cc. syringe?

7

A. Yes.

8

9

Q. And would there on occasion  
as well be use of a 3 cc. syringe to administer  
digoxin?

10

A. There could be, yes.

11

Q. And the 60 cc. as well?

12

A. No.

13

Q. So in the normal situation  
either a 1 cc. or a 3 cc. syringe would be used?

14

A. That is correct.

15

16

Q. I take it you are familiar  
as well, Ms. Bell, by virtue of your experience on  
those wards with the practice that was followed  
generally for the administration of medications  
apart from the use of particular sizes of syringes?

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A. Yes.

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Q. All right. It has been  
suggested in prior evidence that Registered Nursing  
Assistants on those wards were not authorized, nor  
did they in practice, administer medications on either

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ward.

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Does that accord with your recollection

4

and your experience on those wards?

5

A. Yes, it does.

6

Q. Was there ever a situation

7

which you can now remember when a Registered Nursing

8

Assistant did administer a medication on Ward 4B or  
4A?

9

A. She could on occasion if she

10

was feeding a child, giving a child vitamins or

11

just after she stopped feeding.

12

Q. If she did so, was it required

13

that she administer those in the presence of a  
Registered Nurse?

14

A. It was not required, no.

15

Q. Was there any other situation

16

which you can now recall when a Registered Nursing

17

Assistant was permitted to administer a medication

18

on either of those two wards?

19

A. Aside from creams, no.

20

Q. We have also heard from other

21

witnesses that Registered Nurses could administer

22

certain kinds of medications intravenously so long

23

as they did so above the drip bulb or above the  
buretrol.

24

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Does that accord with your recollection of the situation in which a Registered Nurse was permitted to administer medications IV?

A. Yes, that is right.

Q. And I take it digoxin was not one of the medications that was permitted to be administered in that fashion?

A. That is right.

Q. There were, however, certain drugs that could be administered in that way?

A. That is correct.

Q. Was gentamicin one of those?

A. Yes, it is.

Q. Was ampicillin one of those?

A. Yes.

Q. Was Lasix one of those?

A. Yes.

Q. Potassium?

A. Yes. Potassium would be injected into the IV bag itself.

Q. All right. And that could be done by a Registered Nurse?

A. Yes, it was.

Q. What about aldactazide?

A. Aldactazide was given by mouth.





1  
F5 2 Q. And never given intravenously?  
3 A. No.  
4 Q. Digoxin, as we understand it,  
5 however, could and frequently was given orally as you  
6 suggested by Registered Nurses on the wards?  
7 A. Yes.  
8 Q. In those circumstances am I  
9 correct that a second nurse was required to check  
10 both the amount of the drug that was drawn up and  
11 the calculations the first nurse had done in drawing  
12 the dose up?  
13 A. Yes, that is correct.  
14 Q. Was the second nurse required  
15 to physically observe the drug or medication being  
16 given?  
17 A. Being given?  
18 Q. Yes.  
19 A. No.  
20 Q. They required, however, to  
21 observe it being drawn up?  
22 A. That is correct.  
23 Q. And required to do their own  
24 independent set of calculations to ensure that the  
25 right amount had been drawn up?  
A. Yes.







Bell  
dr.ex. (Cronk)

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Q. All right. Were drugs such as gentamicin, ampicillin, Lasix required to be second-checked by a second nurse before they were given?

A. Gentamicin and ampicillin wasn't, but Lasix we would generally check.

THE COMMISSIONER: Sorry, you would generally what?

THE WITNESS: We generally checked Lasix.

THE COMMISSIONER: Oh, all right. The question is, was it required?

THE WITNESS: No, it was not required.

MS. CRONK: Q. I take it there would be occasions when a nurse could administer Lasix intravenously without having checked it with a second nurse?

A. Yes.

Q. Was that true as well of potassium?

A. It wasn't required to have it checked, no.

Q. All right. Was that true as well of aldactazide?

A. That is correct.





F7

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2

Q. What about the drug Mandol?

3

Is that required to be second-checked?

4

A. No, it is not.

5

Q. All right. And is that

6

administered on occasion intravenously?

7

A. Yes, it is.

8

Q. Again would that be administered

9

by a Registered Nurse administered above the drip  
bulb or buretrol?

10

A. Yes.

11

Q. Did you ever during those

12

nine months, Ms. Bell, as best you can now recall it,

13

observe a Registered Nursing Assistant administer a

14

medication intravenously by any route?

15

A. No.

16

Q. Did you personally at any

17

time observe a Registered Nursing Assistant administer-

18

ing a medication of any kind?

19

A. No.

20

Q. Again during the same nine-

21

month period did you on any occasion as best you can

22

now recall it observe a nurse administering a dose

23

of digoxin intravenously?

24

A. No.

25

Q. Did you on any occasion observe





F8

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a nurse administering a dose of any medication below  
the drip bulb or the buretrol?

3

4

A. No.

5

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7

Q. Did you on any occasion  
observe a nurse in circumstances where it was sug-  
gested in your mind that a medication was given  
below the drip bulb or the buretrol?

8

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10

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A. No.

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Q. No recollection at any time  
of having in fact observed a nurse in those circum-  
stances?

A. No.

Q. We have heard as well on  
occasion if a drug was required on either Ward 4A or  
4B and it was not in stock on the ward it could be  
borrowed from another ward.

A. Yes.

Q. In your experience as team  
leader on 4B if a drug was required for a 4B patient  
and it wasn't available in your own medication room,  
would it be first borrowed from 4A before resort was  
had to other wards?

A. Yes, it would be.

Q. Was any record kept of drugs  
that were borrowed as between the two wards?





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A. No. Aside from narcotics  
you wouldn't, no.

Q. Speaking only of non-narcotics  
and non-controlled drugs, if, for example, you wanted  
to borrow a dose of digoxin or obtain a digoxin  
ampoule from the 4A medication cupboard would your  
nurses on your team or you, yourself, be required to  
keep a record of having borrowed that?

A. No.

Q. Would you be required to  
inform the team leader on 4A?

A. Yes.

Q. Were you required to do so  
or did it happen as a matter of courtesy?

A. It happened as a matter of  
courtesy.

Q. All right. And would the  
same apply in reverse?

A. Yes.

Q. So that if a nurse from 4A  
wished to obtain an ampoule of digoxin or some  
digoxin elixir were they free to obtain that from the  
4B medication room without speaking to you?

A. Yes.

Q. And if they did borrow it they







Bell  
dr.ex. (Cronk)

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need not keep a record of having done so?

A. That is correct.

Q. If they were prepared to be discourteous, I take it they needn't inform you?

A. That is right.

Q. And similarly if you went to another ward to borrow a drug of any kind, was a record kept on the other ward that you had borrowed it?

A. There was no record.

Q. Was there a record kept on your own ward if you had obtained drugs from another ward for the purposes of the night shift?

A. No, there wasn't.

Q. You have spoken as well about the various breaks that are available to nurses that are assigned to constant nursing care duties.

May we talk first of the nurses who are on normal patient assignments at night; not constant nursing care duties.

A. All right.

Q. Was there a set time when the nurses in that situation were permitted to take their coffee breaks?

A. There were no set times on nights.





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Q. How many coffee breaks were they allowed during the course of a 12-hour night shift?

A. They were allowed two.

Q. How long was each?

A. Usually fifteen minutes.

Q. So in total they were allowed approximately 30 minutes during the night shift?

A. Yes.

Q. Could they take that break --

THE COMMISSIONER: Well now that doesn't follow from what she said. She said usually fifteen minutes. Do I understand the nurses were pretty well on their honour as to these amounts of time?

THE WITNESS: Yes, they were.

THE COMMISSIONER: You didn't keep check of them?

THE WITNESS: No, I didn't.

THE COMMISSIONER: Were there any rules? There might have been. I think we have seen something about it.

THE WITNESS: There is something in the Policy Manual but we don't --





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THE COMMISSIONER: You don't --

3

THE WITNESS: -- police it or anything.

4

MS. CRONK: Q. The Commissioner's

5

point is well taken: Although they were usually

6

fifteen minutes each they could on occasion be

7

longer?

8

A. Yes, they could.

10

Q. All right. Was it generally

9

a hard and fast rule that no more than two coffee

11

A. Sometimes the nurses would

12

take really short breaks like bathroom breaks or

13

that type of break and we didn't really count that

14

or if you were really busy you would take a break

15

maybe for a few minutes and then go back and do --

16

depending on how your workload was.

17

Q. Was it really up to the

18

individual nurse?

19

A. Yes, it was.

20

Q. Similarly was the nurse who

21

was not on constant nursing care duties permitted

22

a lunch or dinner break during the course of that

23

12-hour shift?

24

A. Yes, she was.

25

Q. Was there a particular time or







1

F13 2 times when it was expected that she would take that?

3

A. No.

4

Q. All right. Again that would  
be up to her discretion?

5

A. Yes, it would be.

6

7

Q. During the same 12-hour shift  
if a nurse was on constant nursing care duties,  
was there a set time when she was permitted to take  
a coffee break?

8

9

10

A. There was no set times.

11

12

Q. Was there a set time when she  
was permitted to take her lunch or dinner break?

13

A. There was no set times.

14

15

Q. All right.

16

You recall, Ms. Bell, on a prior  
occasion testifying at the preliminary hearing  
involving Susan Nelles?

17

A. Yes.

18

19

Q. Do you recall being asked at  
that time about this matter of the breaks and when  
nurses were authorized to take breaks?

20

21

I am referring, sir, to the evidence  
of Ms. Bell at Volume 7 of the preliminary hearing,  
at page 1666.

22

23

To refresh your memory, Ms. Bell, you

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were being asked a series of questions by Mr. Cooper with respect to the taking of breaks by nurses who were assigned to constant nursing care duties and you were asked this question:

"Q. How many reliefs are there generally on the evening shift? Are there usually two or might there be three?"

"A. Two or three, depends."

"Q. Two or three, it depends?

When is the coffee break usually taken? Assuming everything goes well and there are no emergencies on the floor, when usually is coffee break?"

"A. Anywhere from 9:30 till 11:00."

"Q. Anywhere from 9:30 till 11:00?

And that is about what, a half-hour break?"

"A. Yes."

"Q. And then when usually can one expect a lunch break on the evening shift?"

"A. Anywhere from 1:00 to 3:00."

"Q. From 1:00 to 3:00, and a lunch break usually lasts how long?"

"A. 45 minutes."





Bell  
dr.ex. (Cronk)

1  
F15 2 To be fair to you, Ms. Bell, could I  
3 put the question again: If a nurse was on constant  
4 nursing care duties during a 12-hour shift, was there  
5 a particular time frame within which she was  
6 expected to take her lunch or dinner break?  
7 A. She could take it within that  
8 time frame, but again it would be up to what was  
9 happening on the ward and who was available for  
10 relief.  
11 Q. Was it the general practice  
12 that that lunch or dinner break was taken between  
13 1:00 and 3:00 in the morning?  
14 A. On our ward, yes.  
15 Q. Was that true on 4A as best  
16 you can recall?  
17 A. Yes.  
18 Q. Was that true only of constant  
19 care nurses or did that apply to all of the nurses  
20 on the ward?  
21 A. That applied to everyone.  
22 Q. Was there as well a general  
23 time when the first coffee break of the evening was  
24 taken before midnight?  
25 A. Any time as I said there  
between 9:00 and 11:00.





1  
F16 2 Q. Did that apply to all nurses  
3 as well as constant care nurses?  
4 A. Yes.  
5 Q. Similarly after the lunch  
6 break I take it that at some point after three o'clock  
7 before 7:15 in the morning the constant care nurse  
8 would be permitted to take another coffee break?  
9 A. She would be permitted, yes.  
10 Q. All right. And was there a  
11 set time frame then when that break was expected to  
12 be taken?  
13 A. No, there wasn't.  
14 Q. Was there a time as a matter  
15 of normal practice when it was taken?  
16 A. No. Generally after our  
17 lunch break we would be quite busy and a lot of times  
18 we wouldn't get a break after our lunch break after  
19 3:00.  
20 Q. How long was the lunch or  
21 dinner break that was taken?  
22 A. 45 minutes.  
23 THE COMMISSIONER: I'm sorry, what  
24 did you say it was?  
25 THE WITNESS: 45 minutes. Maybe a  
few minutes longer.







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MS. CRONK: Q. Did that apply to nurses who were on constant care as well as nurses who were not?

A. Yes.

Q. As a general matter when nurses on those wards at night were taking their lunch or dinner break, would a number of them from Wards 4A and 4B take it at the same time and meet together at the nursing station?

A. Yes.

Q. Did that apply as well to coffee breaks?

A. Yes.

Q. So at any given time there could be nurses from both wards together sharing their coffee break or sharing their dinner break?

A. That is correct.

Q. And that could happen with respect to coffee breaks several times over the course of any 12-hour shift?

A. Yes, it does.

THE COMMISSIONER: Several times?

MS. CRONK: Over the course of any 12-hour shift.

THE COMMISSIONER: Well, perhaps you





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are right. I thought they were only supposed to have two coffee breaks. Is that right?

3

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THE WITNESS: They are only supposed to, but on some occasions it would happen that one night you would not get any coffee break and on another night you might have perhaps more than two.

5

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MS. CRONK: Q. There would be no restriction on a nurse from either 4A or 4B sitting down at the nursing station to take another coffee?

9

10

11

A. No, there wouldn't be.

12

13

14

15

Q. All right. As I understand it, Ms. Bell, turning again to the nine-month period that we are concerned with, you were on duty on Ward 4B at a time when a number of children whose deaths are under review by this Commission occurred.

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A. Yes.

Q. Is that correct? And am I correct with respect to some of those deaths you have a specific recollection either of the patient or the circumstances of the patient's death, but in other cases you do not have a recollection of the circumstances surrounding their deaths?

A. That is correct.

THE COMMISSIONER: Before you go on,





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Ms. Bell, where was this coffee acquired? Did you have pots of coffee?

THE WITNESS: We have our own coffee maker and we would have it at the nursing station at the back.

THE COMMISSIONER: So the nurse would just simply go in and pour herself a cup of coffee?

THE WITNESS: That is correct.

THE COMMISSIONER: It is not of vital importance: was there any charge for this or did you just get it?

THE WITNESS: We would take turns buying the coffee.

THE COMMISSIONER: Oh, you had to pay?

THE WITNESS: Well, we would buy a package.

THE COMMISSIONER: Oh, I see. Yes, that's a little better. That seems to be the only graft I get here. I have free coffee that I get twice a day.

MS. CRONK: Q. Ms. Bell, there are a great many children who died during this nine-month period on the wards, and in an attempt perhaps to make it less confusing for all of us I have set out on a summary sheet a list of those patients who died







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as I understand it, when you were on duty, the date  
of their death and the place of their death.

Have you seen this before?

A. Yes, I have.





G/DM/ak

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Q. Have you had an opportunity to review the hours of duty that are set out on the right hand side of the page?

A. Yes, I have.

Q. And with respect to each child set out on the left hand side of the page do the duty hours recorded record the hours that you worked in relationship to the time of death for a particular child?

A. Yes, they do.

Q. Am I correct, Ms. Bell, that with respect to the first 15 children set out on this list you do have a specific recollection, either with respect to the child or some of the circumstances that applied at the time they died?

A. Yes.

Q. And as well at the bottom of the page there are five other children listed, am I correct that you were on duty at the hours indicated when those children died?

A. Yes, I was.

Q. Am I correct however that your recollection with respect to those patients and the circumstances surrounding their death is less clear than it is with respect to the other





1

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children listed on this sheet?

3

A. Yes, it is.

4

Q. And you have had a chance to

5

check the hours of duties specifically that are

6

set out on the right hand side of the page?

7

A. I have.

8

THE COMMISSIONER: Does it mean

9

you were on duty in that particular ward or in one

10

of those two wards in question? For instance, would

11

you have been with Laura Woodcock, would you have

12

been in Ward 4B; and would you have been with Alan

Perreault in Ward 4A?

13

THE WITNESS: I was on Ward 4B for

14

all of these.

15

THE COMMISSIONER: For all of these.

16

THE WITNESS: Yes.

17

MS. CRONK: May that be marked,

sir, as the next exhibit?

18

THE COMMISSIONER: Yes, 344.

19

MS. CRONK: Thank you, sir.

20

---EXHIBIT NO. 344: List of children relevant to  
evidence of Bertha Bell.

21

22

MS. CRONK: Q. May we deal first,

23

Ms. Bell, with the death of Laura Woodcock. As you

24

25





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know she died on Ward 4B on June 30th at 9:40 a.m.

3

As I understand it you worked the long night shift

4

on June 29th, do I have that correctly?

5

A. That is right.

6

Q. When you reported for work on

7

the night shift on the 29th of June what were you

8

told of Laura Woodcock's condition?

9

A. That she was stable.

10

Q. Did you have any reason to

11

believe at the beginning of that shift that she

was seriously ill?

12

A. She was - can you clarify

13

"seriously ill"; she was on a monitor.

14

Q. Was she on a cardiac monitor?

15

A. She was on a cardiac monitor.

16

Q. Perhaps this will make it

17

slightly clearer for you, Ms. Bell. When you

18

reported for duty that night and took report from

19

the day team leader, was there any indication that

20

Laura Woodcock was expected to be at imminent risk  
of death?

21

A. Not at imminent risk of death,

22

no.

23

Q. Indeed was it even suggested

24

that her condition throughout that night shift

25







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might be regarded as likely to be critical?

3

A. No.

4

Q. Can you turn please again to

5

the Ward 4B WIN sheets, do you still have that,

6

Exhibit 334?

7

A. Yes, I do.

8

Q. The very first page, June 29th,

9

am I interpreting this correctly, Ms. Bell, if I

10

were to suggest that the nurses on Ward 4B on June

11

29th, the night before Laura Woodcock died, was

yourself, Ms. Harder and Ms. Bracewell?

12

A. That is correct.

13

Q. Do you recall what room Laura

14

Woodcock was assigned to?

15

A. She was in Room 431.

16

Q. We have had some difficulty,

17

Ms. Bell, as you are perhaps aware, the Ward 4B

18

assignment book for this period the summer and

19

fall of 1980 is missing. Can you help me as to how

you know Laura Woodcock was in that room?

20

A. I just recall that she was

21

in the corner by the window closest to the nursing

station.

22

Q. Do you know to whose care she

23

had been assigned?

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A. Mary Anne Bracewell.

Q. Was she on constant nursing care or shared nursing?

A. No, she wasn't.

Q. There were a number of other patients I take it in Room 431 at the same time?

A. Yes.

MS. CRONK: Mr. Registrar, could you show Ms. Bell if you would please Exhibit 335.

Q. These are the WIN sheets for Ward 4A, Ms. Bell, and looking at June 29th, could you tell me if I am interpreting this correctly if I suggest that Phyllis Trayner, Susan Nelles and Sui Scott were working long nights on Ward 4A that evening?

A. That is correct.

Q. Did Laura Woodcock's condition deteriorate during the course of the night shift when you were on duty?

A. Yes, it did.

Q. Did anything of concern specifically happen with the child before you completed your shift?

A. She had some irregular, heart irregularities and we had notified Dr. Schaffer.





Bell, dr.ex.  
(Cronk)

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Q. When did you notice, Ms. Bell,  
or when were you first informed that her condition  
appeared to be deteriorating?

A. I believe it was around 5:00  
or 6:00, it would be the 30th of June, in the morning.

Q. Do you recall now how it was  
that you became aware that her condition had  
changed?

A. Mary Anne Bracewell alerted  
me to that, her condition was changing, her alarm  
from her cardiac monitor was sounding, and she had  
started out that the alarm would go off and then  
she would be checked and her vital signs were stable,  
there was no outward change that we could see so we  
initially didn't call the doctor.

Q. Well, inasmuch as this  
child was on 4B I take it that in addition to hearing  
about her when you took report at the beginning of  
the shift, you actually saw her when you made  
rounds?

A. Yes.

Q. And that would have been at  
approximately what time during the evening?

A. Probably it would be between  
8:00 and 9:00.







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Q. Was her condition at that time  
stable as it had been when you came on duty?

4

A. Yes.

5

6

7

Q. And you have told us that  
Ms. Bracewell informed you in the early hours of  
the morning, I think you said approximately 5 o'clock.

8

9

A. I believe it was 5:00 or 6:00,  
I can't remember exactly.

10

11

12

Q. During that period from  
approximately 9:00 p.m. on June 29th until 5:00 a.m.  
on the morning of June 30th had you personally  
seen Laura Woodcock?

13

A. Yes.

14

15

16

Q. Do you recall whether or not  
her condition had changed at any time when you had  
observed her during that evening?

17

18

19

A. She was stable.  
MS. CRONK: Mr. Registrar, could  
you show Ms. Bell if you would the medical record  
for Laura Woodcock, that is Exhibit 117.

20

21

22

Q. Ms. Bell, have you had an  
opportunity over the last several months to review  
the medical charts of these various children?

23

A. Yes, I have.

24

25

Q. And have you done so recently?





Bell, dr.ex.  
(Cronk)

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A. Yes.

4

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Q. I would ask you to turn if you would to page 48, Ms. Bell, which is part of the progress notes from that night shift on June 29th.

6

A. I have it.

7

8

9

Q. I would ask you to look if you would please at the nursing note which appears at the bottom of the page, June 30th at 3:00 a.m., do you see that?

10

A. Yes, I do.

11

12

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Q. An indication that the child vomited a large amount of formula; that her cardiac monitor reading had become - was showing an irregular heart rate following the vomiting episode; and the other vital signs of the child are recorded as having been stable. Then there is an indication that the team leader, I take that to be yourself, was informed by Ms. Bracewell of these events?

18

A. That is correct.

19

20

21

Q. Do you recall seeing the child at that time or were you merely informed of the events that were recorded by Ms. Bracewell?

22

A. I remember seeing the child.

23

Q. You would have seen the child?

24

A. Yes.

25





Bell, dr.ex.  
(Cronk)

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G9

Q. Is that the turn in her condition that you described a few moments ago?

A. I believe it is, yes.

Q. It happened and it appears at approximately 3 o'clock in the morning?

A. Yes.

Q. Did the child's condition stabilize after that particular episode?

A. When I had gone back into the room with Ms. Bracewell there was no irregularities in the child's heart and the child had settled and was comfortable.

Q. Other than that episode then, before you reported off duty that morning, was there any further or other apparent deterioration in this child's condition?

A. Yes, there was.

Q. When did that occur?

A. According to the chart it occurred at 6:00.

Q. Do you recall seeing the child at 6:00 in the morning?

A. Yes.

Q. How did that come about?

A. Again Ms. Bracewell had let





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me know about it.

Q. Do you recall her in fact  
having done so?

A. I remember checking the child,  
yes.

Q. And how had her condition  
changed since you had seen her at 3 o'clock?

A. Well her vital signs had  
changed, her heart rate was now irregular and as  
the note says she was more lethargic.

Q. I take it MMs. Bracewell,  
inasmuch as this child was not on constant nursing  
care that night, would have been in and out of  
Laura Woodcock's room during the course of the  
evening?

A. I imagine she would have,  
yes.

Q. Were you yourself in and out  
of her room after 3 o'clock to check on her progress?

A. Yes.

Q. At 6 o'clock when this  
episode occurred was a Code 23 called at that stage?

A. I don't know if we called  
a 23, I know the doctor came.

Q. You don't recall whether that







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happened by accident, or whether or not he was particularly concerned?

A. We had called him, but whether we called a 23, he came immediately.

Q. Was that Dr. Schaffer?

A. Yes, it was.

Q. And what was Dr. Schaffer's view as you understood it of her condition at that time?

A. Well that she was reasonably stable; that he would do some blood work and go from there.

Q. If you take a look at page 50 of the progress notes, I think you were looking at those a few moments ago?

A. Yes.

Q. The episode at 6:00 a.m. which you have described is set out. There is an indication by Mrs. Bracewell that you were notified of the difficulties that the child was in. The very next note is at 7:00 a.m. and it indicates that Dr. Schaffer was present. Do you recall, as best you can recall, is that when Dr. Schaffer was in attendance, or would he have been there either at 3 o'clock or 6 o'clock for those particular





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episodes?

A. I can't recall.

Q. Was it your impression then when Dr. Schaffer was there that he intended to do a number of tests, blood work on the child, but that in his view she appeared to be relatively stable?

A. Yes.

Q. How would you describe, in your judgment, her condition when you left your shift that morning?

A. There was reason for concern, she needed to be attended - depending on what the blood work showed, or she needed a doctor around.

Q. Was she being treated as seriously ill when you gave a report at 7:15 that morning?

A. Yes.

Q. Was she still, however, on the ward?

A. Yes, she was.

Q. Had constant care nursing been introduced for her?

A. I don't know.

Q. Was it in your mind desirable at that stage that she be observed in the way that





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constant care nursing would permit it?

A. I would think so, yes.

Q. Did you recommend it to the nurses coming on duty?

A. I suggested that she be watched very closely, there was somebody in the room.

Q. Was Dr. Schaffer still with her when you left work that morning?

A. Yes, he was.

Q. Had a Code 23 or a Code 25 been called for her at that stage?

A. No, not at that point, no.

Q. During the course - we know that later in the morning, indeed approximately 9:00 a.m. the child did go into cardiac arrest and she was pronounced dead at approximately 9:40 in the morning. When you learned of her death having regard to the conditions that you observed during the course of that evening, were you surprised?

A. I guess I have to say surprised on one hand, because I don't honestly expect - I am surprised at any child's death; but not surprised on the other hand because when I left that morning she was ill.







G14

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Q. When you left, Ms. Bell, did you think the child was dying?

4

A. Not at that point, no.

5

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Q. Did you expect her to die that day?

7

A. I can't say as I did, no.

8

9

Q. Indeed, in your mind was there an apparent explanation for her death when you learned of it?

10

A. No.

11

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Q. So far as you were aware were the doctors who had seen the child and who were in attendance at the time of her arrest able to readily explain why in fact she had died?

15

A. No.

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Q. Could I refer you to page 50 as well of the progress notes, Ms. Bell. It appears from those notes that Dr. Schaffer at 7:30 in the morning, the morning of Laura Woodcock's death, was questioning toxicity. In one passage on the left hand side of the page toxicity is noted and then bilirubin toxicity is noted on the other side at the bottom of the page.

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Based on your own observations of Laura Woodcock during the course of that evening





G15

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did it occur to you that toxicity from any particular  
drug might be causing the episodes that you had  
observed?

5

A. No.

6

7

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Q. Did you at any point while  
Dr. Schaffer was in attendance on the ward discuss  
with him the possibility of toxicity from any drug?

9

A. No, not that I recall, no.

10

11

Q. Did he raise it with you

as best you can recall it?

12

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A. No.

Q. Was there any suggestion made  
in your presence or of which you heard, that digoxin  
may have played a part in this child's death, or  
indeed digoxin toxicity?

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BmB.jc  
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Q Did you see Dr. Schaffer's note  
in the medical chart before you left that morning?

A No, I did not.

Q Do you recall any discussion  
amongst your own team members regarding the possibility  
of digoxin toxicity concerning this child?

MS. CRONK: Sir, could we take our  
break now?

THE COMMISSIONER: Yes, 20 minutes.

--- Short recess

--- Upon commencing:

THE COMMISSIONER: Yes, Miss Cronk?

MS. CRONK: Q Ms. Bell, do you still  
have the medical chart of Laura Woodcock there?

A Yes, I do.

Q Could I ask you to turn to page  
59 if you would, please; that is the medication and  
treatment record for this child.

A I have it.

Q Could you indicate for us  
please the medications that are recorded as having  
been given to the child during the night shift on  
January 29th - I'm sorry, June 29th, I said January;  
June 29th?

A Ampicillin.





H.2

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Q And that was given when?

3

A That was given at 2400 hours.

4

Q That's midnight?

5

A Yes.

6

Q And that was signed for by

Ms. Bracewell?

7

A Yes.

8

Q As a general rule did the nurse

9

who was administering a medication to a patient sign

10

the medication treatment record?

11

A Yes, she would.

12

Q Were there ever situations of

13

which you were aware when a nurse other than the nurse

14

who had administered the medication signed the

15

medication treatment record indicating that the

16

medication had been given?

A It has happened.

17

Q It could happen?

18

A It could.

19

Q All right. Other than the

20

ampicillin that appears to have been given at midnight,

21

am I correct that there is no other medication recorded

22

on this sheet as having been given to the child at

all during that 12-hour shift?

23

A That's right.

24

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H.3

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Q. Would you turn now if you would  
to page 50. Do you have that?

4

A. Yes, I do.

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Q. And I am referring to the  
entry recording that Dr. Schaffer attended to see the  
child at 7 a.m.; that is the nursing note completed  
by Ms. Bracewell.

8

A. Yes.

9

Q. Do you see that?

10

A. Yes.

11

12

13

Q. Am I correct as well that it  
would appear that Dr. Schaffer gave a dose of  
atropine to the child by I.V. at approximately five  
after eight in the morning?

14

A. That is correct.

15

16

Q. And the amount of that was .04  
milligrams?

17

A. That's right.

18

19

20

Q. Other than those two medications,  
Ms. Bell, are you aware of any other medication having  
been given to this child over the 12-hour night shift?

21

A. No.

22

Q. Did you personally observe the  
atropine being given by Dr. Schaffer?

23

A. No, I didn't.

24

25





H.4

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Q. Had you left the ward by that time?

4

A. No, I believe I was in report.

5

Q. Did you observe the ampicillin being given at midnight by Ms. Bracewell?

6

A. No.

7

8

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Q. At any time during that long night shift from the time that you came on duty until the time you left after having given report in the morning, did you at any time observe anyone giving any medication or drug to this child?

12

A. Not that I can recall, no.

13

14

15

16

Q. Other than the dose of ampicillin that was given at midnight by Ms. Bracewell, was there any incident reported to you or did you hear of any incident wherein the child received another medication from anyone else?

17

A. No.

18

19

20

Q. Did you yourself, Ms. Bell, at any time during that 12-hour shift administer any medication to this child?

21

A. No.

22

23

24

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Q. According to the Ward 4B WIN sheets you were next on duty on July 2nd, 1980. I take it that when you came in that day you would have





H.5

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heard of the child's death?

3

A. Yes.

4

Q. You weren't still in the

5

Hospital when she was pronounced dead on the 30th I  
take it?

6

A. No, I wasn't.

7

Q. At the time that you learned of

8

her death, was there any concern expressed by any

9

members of the nursing staff, be it from 4B or 4A,

10

concerning the way in which the child had died or the

11

cause of her death?

12

A. Not that I recall, no.

13

Q. Did it still at that time, that

14

is, July 2nd, appear to be an unexplained death?

15

A. We had no cause of death, that's

16

right.

17

Q. Did you discuss the matter of

18

her death with any of the cardiologists on the ward?

19

A. No, I did not.

20

Q. At any time to your knowledge

21

after her death was an explanation as to the cause of  
her death forthcoming which you felt to have been  
satisfactory?

22

A. I don't recall hearing a cause

23

of death, no.

24

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Q. Was the cause of her death in your own mind then still a puzzle as you sit here today?

A. I don't know what you mean by puzzle?

Q. As you sit here today, can you help us as to whether or not there was a cause of death advanced with respect to this child that you felt explained her death?

A. I believe there was.

Q. Do you know now what that was?

A. Not offhand I don't, just going from the chart before.

Q. All right. Do you recall when you learned of that?

A. Not until I had gone through the charts within the past couple of months.

Q. Was there something in the chart when you reviewed it that suggested itself as the cause of her death?

A. The post mortem.

Q. All right. When you saw the autopsy report on this child, did you feel then that her death had been explained?

A. Yes.

Q. Was there anything particular in





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the autopsy report that you felt accounted for her death?

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A. I can't recall.

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Q. All right. The next child who died during that nine-month period, Ms. Bell, was Alan Perreault, who died on July 8th in the early hours of the morning at approximately 1:45 - I'm sorry, he died at 1:45 p.m. in the afternoon on July 8th on Ward 4A. Looking at the summary sheet that we've prepared, as I understand it, you were on duty the long 12-hour day shift on that day?

12

A. Yes, I was.

13

14

Q. Do you recall seeing Alan Perreault that morning when you came on duty?

15

16

A. No, I didn't see him.

17

18

19

20

Q. Did you see him at any time during that shift?

21

22

23

24

25

A. Yes, I did.  
Q. Can you help me first as to what you understood his condition to be when you reported for duty that morning?

A. I believe there was a 'do not resuscitate' order written on his chart.

Q. Was he considered at that time to be very seriously ill?





H.8

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A. Yes, he was.

3

Q. Was he expected to be at

4

imminent risk of death?

5

A. Yes.

6

Q. And you have told us that you

7

did see him. When was that, when was the first time  
that you saw the child during that 12-hour shift?

8

A. Shortly before he died.

9

Q. And how did that come about?

10

A. Phyllis was in the room and she

11

asked me to come in with her. His respirations were  
very shallow or they were absent and she just wanted  
somebody with her.

13

Q. Do you recall what time that was?

14

A. I had gone in a few minutes

15

before he had died, I don't recall the exact time, no.

16

MS. CRONK: Mr. Registrar, could you

17

show Ms. Bell, please, Exhibit 58, Alan Perreault's  
medical chart.

18

19

Q. When you entered the child's

20

room, Ms. Bell, were you in a position to actually  
observe him?

21

A. Yes.

22

Q. And what did you feel his

23

24

25





H.9

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condition was at that time?

3

A. That he was about to die.

4

Q. And what led you to that

5

conclusion?

6

A. As I said, his respirations

7

were very shallow or they were absent totally. He

8

was on a cardiac monitor and there was no activity  
on the cardiac monitor.

9

Q. And do I have it that that was

10

the first time that you had seen that child during

11

that entire shift?

12

A. Yes.

13

Q. I would ask you to turn to page

14

43 if you would. Page 43 contains the nursing note

15

from 7:30 in the morning until 13:45 in the afternoon.

16

It reads June 8th but in fact it would appear to be

17

A. Yes.

18

Q. He appears to have gotten into

19

difficulty at approximately 1:15 in the afternoon

20

while being fed by Phyllis Trayner, according to the  
note?

21

A. Yes.

22

Q. Do you see that?

23

A. Yes.

24

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Q. When you entered the room was there anyone there other than Phyllis Trayner?

A. No, there was just Phyllis.

Q. Did you remain in the room then until the child was pronounced dead?

A. I called Dr. Contreras to come to the ward and some activity occurred again on the cardiac monitor. He didn't die at that time. Dr. Contreras left the ward and then Phyllis called me back again and at that time he actually did die and was pronounced dead. So, I had gone in twice.

Q. All right. Well, the first time that you had gone in the room, did you have to leave the room to call Dr. Contreras?

A. Yes, I did.

Q. And did Dr. Contreras in fact come and see the child?

A. Yes, he did.

Q. Was it at that time that there appeared to be some resumption of activity on the cardiac monitor?

A. Yes, there was.

Q. And do I have it that at that stage the doctor then left?

A. Yes, he did.





H.11

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Q. And did you?

3

A. Yes.

4

Q. And when then did you next

5

return to the room?

6

A. Just shortly before he died

7

again or was pronounced dead.

8

Q. Well, was it a matter of moments

after you left the room or was it several minutes?

9

A. It was several minutes.

10

Q. And how was it that you then

11

returned to the room again?

12

A. She called me again.

13

Q. And what was the child's

condition this time when you went in the room?

14

A. The same, had absence of

15

respirations, no activity on the cardiac monitor.

16

Q. And was there any doctor

17

present in the room at that time?

18

A. No, there wasn't.

19

Q. Was a call made for a doctor

20

at that stage?

21

A. Yes, I called Dr. Contreras

again.

22

Q. And did he return?

23

A. And he returned and pronounced

24

him dead.

25





H.12

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Q. During the course then of your two visits in that room when you were observing the child's condition, did you observe anything which in your judgment you would regard as unusual in the symptoms that the child was displaying?

A. No.

Q. And you have told us that there was a 'do not resuscitate' order in place with respect to this child?

A. I believe there was, yes.

Q. Were any resuscitation efforts in fact undertaken on either of those two occasions?

A. No.

Q. Did you at any time that morning while you were on duty before entering the room when Mrs. Trayner first called out to you, observe any individual administering any medication to this child?

A. No.

Q. Did you at any time observe any individual going into Alan Perreault's room with a syringe in hand?

A. Not that I recall, no.

Q. Was it ever reported or suggested to you that any individual had administered digoxin







H.13

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to that child while he was at The Hospital for Sick  
Children?

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A. No.

5

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Q. Could I ask you then if you  
would, please, to look at Exhibit 42 - Mr. Registrar -  
which is the medical chart of Andrew Bilodeau. This  
child died, Ms. Bell, again on Ward 4A on July 22nd  
at approximately 2 o'clock in the morning and  
according to the summary sheet it is my understanding  
that you were on duty on the 12-hour long night shift  
on July 21st, the night prior to his death?

12

13

A. That was the night of his death,  
yes.

14

15

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Q. The night of his death.

A. Yes.

Q. And you were on duty then?

A. Yes.

Q. The 12-hour night shift?

A. Yes.

Q. Did you observe this child at  
any time during that 12-hour night shift?

A. Just during the arrest.

Q. All right. Well, prior to the  
arrest what did you understand the child's condition  
to be?





H.14

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A. I can't recall.

3

Q. All right. Well, we know that

4

he was on Ward 4A, so, I take it you would not have

5

received a specific report about him when you came

6

on duty?

7

A. That's right.

8

Q. You have also told us however

9

that Mrs. Trayner as the team leader on 4A informed

10

you as to those patients on her ward considered to be

11

most seriously ill.

A. Yes.

12

Q. Do you recall whether or not

13

Andrew Bilodeau was considered to be critical that

14

night?

A. I don't recall if she told me

15

or not, no.

16

Q. You have no recollection at all

17

of what his condition was regarded as being that

18

evening?

A. No.

19

Q. When then was the first time

20

that you saw the child?

21

A. During the arrest.

22

Q. All right. And how is it that

23

you saw the child at that time?

24

25





H.15

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A. A Code 25 was called and I  
would have gone into the room to assist.

3

4

Q. Prior to a Code 25 being called,  
had you been in the child's room at any time?

5

6

A. I don't think so.

7

8

Q. Could I ask you to turn to page  
38 if you would of the medical record?

9

10

A. I have it.

11

12

Q. Once again, could you help us  
please, Ms. Bell, with the medications which are  
recorded as having been given to this child during  
that night shift?

13

14

A. She was given digoxin at 2100.

15

16

Q. That's at 9 p.m. in the evening?

17

18

A. At 9 p.m. in the evening, yes;

but he vomited and again he was given aldactazide at  
9 p.m. in the evening but he vomited that as well.

19

20

Q. Who gave him the digoxin at  
9 o'clock?

21

22

A. Susan Nelles.

23

24

Q. And that was given orally?

25

A. Yes.

Q. And what was the amount that was  
given?

A. .015 milligrams.





H.16

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Q And similarly the aldactazine  
was given at 9 o'clock as well?

4

A Yes, it was.

5

Q Was that given by the same  
individual?

6

7

A By Susan Nelles and 6 milligrams  
were given by mouth.

8

9

THE COMMISSIONER: I'm sorry, what  
page is this?

10

11

MS. CRONK: Page 38 of the medical  
record, sir. It is the Medication and Treatment Record  
for this child.

12

13

THE COMMISSIONER: Oh, yes, I think I  
have it, yes, thank you.

14

15

MS. CRONK: Q Did you observe either  
of those medications being given to this child?

16

A No, not that I recall, no.

17

18

19

Q Apart from the two which are  
recorded here, were you informed at any stage either  
during his arrest or thereafter that any other  
medication had been given to him during that shift?

20

21

A No.

22

Q I would ask you to turn if you  
would please, to page 24.

23

24

25

A I have it.







H.17

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2

Q. Do you have it?

3

A. Yes.

4

Q. This is the nursing note

5

apparently completed by Ms. Nelles concerning the

6

night of the child's death from 1900 hours in the

7

evening until 1 o'clock in the morning and then from

1:25 in the morning onwards.

8

A. Yes.

9

Q. Am I correct that this child,

10

Ms. Bell, was on an I.V. apparatus?

11

A. Yes, the I.V. was started at

12

2230.

13

Q. That is 10:30 in the evening?

14

A. Which is 10:30 in the evening,

yes.

15

Q. And according to the nursing

16

note it appears to have been infusing well?

17

A. Yes.

18

Q. And there is also an indication

19

as to the attempted feeding of the child, is that

20

correct, under Nutrition?

21

A. Oh, yes.

22

Q. All right. What appears to have

23

happened with this child's feedings during the course

24

of that night shift?

25





H.18

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A. Vomiting.

3

Q. He appears to have been fed,

4

does he not, at the time at 9 o'clock when the

5

aldactazide and the digoxin was given but he vomited

6

both the drugs and the formula that he was being fed?

7

A. Yes.

8

Q. Was it not then attempted to

feed him by nasogastric tube?

9

A. Yes.

10

Q. And the child didn't keep that

11

down at all?

12

A. No, vomited once again.

13

Q. And then the very next entry I

14

suggest, and I would ask you to confirm, appears to

15

indicate that another drug was given to the child,

16

this time 3 milligrams of Lasix. Do you see that?

17

A. Yes, I do.

18

Q. Can you read the rest of the

line for me?

19

A. It was given IM stat. at either

20

2200 or 23 hours, I'm not sure.

21

Q. What does IM stat refer to?

22

A. Intramuscularly immediately.

23

Q. And the time you think is what?

24

A. It is either 2200 or 2300, it

is hard to read.

25





H.19

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2

Q. Does there then appear a name

3

beside that?

4

A. P. Morrin, R.N.

5

Q. Do I correctly take from that,

6

that that dose of Lasix then was administered by

7

Mrs. Trayner?

A. Yes.

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Q. Were nurses authorized to administer drugs intramuscular?

A. Yes, we were.

Q. Could that be done in the absence of a physician?

A. Yes.

Q. And that dose as you have suggested appears to have been given either at 10 o'clock or at 11 o'clock that evening?

A. Yes.

Q. Did you observe the administration of that dose to this child?

A. Not that I recall, no.

Q. The Code 23 according to the nursing note on this page appears to have been called at approximately 1:25 in the morning?

A. Yes.

Q. And a Code 25 within two minutes?

A. Yes.

Q. Am I correct then in reviewing these progress notes and the medication treatment record that the last recorded medication that this child apparently received was the dose of Lasix administered either at 10 o'clock or 11 o'clock in





I.2

1

2

the evening?

3

A. That is correct.

4

Q. Did you at any time during

5

the course of this night shift, Ms. Bell, have

6

occasion to administer any medication of this child

7

yourself?

8

A. No.

9

Q. Was the nursing staff to the

10

best of your knowledge concerned about the cause of

11

A. Not that I recall, no.

12

Q. When the child went into the

13

cardiac arrest you have told us that you were - I'm

14

sorry, you told us you were called into the room

15

when there was a Code 25?

16

A. Yes.

17

Q. Were you there before the

18

Code was called?

19

A. I could have gone in when the

Code 23 was called.

20

Q. Did you observe any physicians

21

in the room when you were there?

22

A. Not that I recall, no.

23

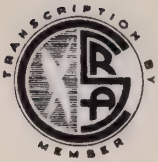
Q. Do you recall Dr. Reynolds

being in attendance?

24

25





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I.3

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A. It says that he was but I  
don't recall.

4

5

6

Q. Do you recall discussing this  
child's death or the cause of his death with  
Dr. Reynolds at any time?

7

A. No.

8

9

Q. Did you in fact discuss this  
child's death with any members of the medical staff  
of the cardiology unit?

10

11

A. Not that I recall, no.

12

13

14

Q. After the child died did there  
appear to be a concern amongst the nursing staff  
insofar as you were aware as to the cause of his  
death?

15

16

17

18

19

20

A. I believe our concerns were  
related to this was in fact the first arrest that  
we had been involved in either in a long period of  
time. We were very unorganized and there was a  
question of had we been a bit better organized or  
had we noticed things earlier could something have  
been done; that type of conversation went on.

21

22

23

Q. I'm sorry, when you say it  
was the first arrest that you had been involved in,  
are you referring to yourself specifically?

24

25

A. To myself and Susan and Phyllis





I.4  
1  
2 and the other members of my team.

3 Q. Laura Woodcock had had an  
4 arrest and died on June --

5 A. We were not directly involved  
6 with that one.

7 Q. Your team was not?

8 A. No. Not with the actual  
9 arrest.

10 Q. Are you suggesting that neither  
11 Mrs. Trayner nor Miss Nelles were involved in the  
12 arrest procedures on Laura Woodcock?

13 A. I believe they weren't.

14 Q. All right. What about Alan  
15 Perreault? There had been an arrest for that child.

16 A. Well, there were no active  
17 resuscitation attempts made.

18 Q. In the case of Laura Woodcock  
19 you will recall that we reviewed the nurses that  
20 had been on duty on June 29th, and apart from those  
21 who were on duty on 4B we looked at those who were  
22 on duty on 4A and found that they were Mrs. Trayner,  
23 Miss Nelles and Miss Scott.

24 Now if your team was not involved in  
25 the arrest and resuscitation on Laura Woodcock I  
take it that 4A nurses necessarily would have had







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I.5 to be?

A. They wouldn't; they were on the same time we were so that meant when we went home they went home so they weren't actively involved.

Q. So then in the case of Andrew Bilodeau it was the first time that your team was actively on duty and present when an arrest and Code 25 were called?

A. That is correct.

Q. All right. Then you suggested that you felt the arrest was disorganized?

A. Yes.

Q. In what sense?

A. In what each person's role was as to what we should be doing as in drawing up medications or recording, et cetera. We needed the direction of a supervisor.

Q. Was that the first time that your team had ever been involved in a Code 25 situation on those wards?

A. On those wards, yes.

Q. To the best of your knowledge was it the first time that Phyllis Trayner's team had been involved in a Code 25 situation on those





1

2

wards?

3

A. On those wards, yes.

4

Q. And was there in fact a

5

nursing supervisor in attendance during the arrest

6

and resuscitation effort for Bilodeau?

7

A. Yes, there was.

8

Q. Who was that?

9

A. I believe it was Cathy

10

Coulson and - I just recall Cathy being there.

11

Q. What role would the nursing

12

supervisor play during the resuscitation if she

were in attendance?

13

A. She would assess the situation

14

and if there was some disorganization she would

15

organize it. If there were things that had to be -

16

medications, extra medications to get, she would

17

get them or if there was anything that had to be

18

done, labs, dealing with labs or getting some other

doctors she could perhaps do that as well.

19

Q. Well, apart from what you have

20

described as the disorganization that occurred with

21

respect to that arrest, in the conversations and

22

discussions that took place amongst the nursing

23

staff was there concern as well as you understood

24

it regarding what had caused this child's death

25

I.6





1

2

or the timing of his death?

3

A. There is a concern why the  
child had died, yes.

4

5

Q. But did you - I'm sorry.

6

A. I am sorry. That is a normal  
concern when a child dies; we are concerned as to  
the reason why.

8

9

Q. Did you have the impression  
at the time after he had died, Ms. Bell, that he had  
been expected to die?

10

11

A. Not that I recall.

12

13

Q. Did there seem to be some  
degree of uncertainty amongst the nurses as to  
why he had actually died at the time that he had?

14

15

A. Again it is uncertainty.  
Because it involves a child there is always an  
uncertainty because they are young and to be quite  
honest you don't honestly expect a child to die.

16

17

18

Q. Did there seem to be in this  
particular case any degree of shock amongst the  
nurses that a child had died other than the normal  
reaction you would have expected given that a child  
died at all?

19

20

21

22

A. I believe there was the normal  
reaction. I don't think there was shock.

23

24

25

I.7







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Q. Was it ever suggested to you  
or did you ever hear from any source the suggestion  
that digoxin may have played some part in this  
child's death?

6

A. No.

7

8

Q. Was that a matter that was  
raised in your presence by any of the cardiologists  
or any members of the nursing staff?

9

10

A. Not that I recall, no.

11

12

13

14

Q. As I understand it, Ms. Bell,  
after Andrew Bilodeau died you worked the long  
night shift on July 22nd, and on July 23rd you  
commenced holidays and didn't return to duty at  
the Hospital until August 4th.

15

Do I have that correctly?

16

A. Yes.

17

18

Q. Did you have occasion to  
come into the Hospital for any reason during that  
period of time?

19

A. No.

20

21

Q. Notwithstanding that you  
weren't working?

22

A. No.

23

Q. Do you remember doing so?

24

A. I didn't go in, no.

25





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Q. During that 10-day period when you were absent from the Hospital four more children died on those wards: David Taylor died on the 27th, Amber Dawson died on July 28th, Lillian Hoos on July 21st and Philip Turner on August 1st.

When did you first learn of the deaths of those children?

A. When I returned back to work on August 4th.

Q. All right. Do you recall who told you that the children had died?

A. A number of people had told me that those children had died. Phyllis, Susan, the girls from my team.

Q. You are referring to Mrs. Trayner and Susan Nelles?

A. Yes.

Q. When you came in on August 4th I have suggested that you worked the long day shift. Did you take report when you came in that morning?

A. Yes.

Q. Was it at that time that you learned for the first time of the deaths of these children?





1

2

A. Yes.

3

4

Q. You would not have taken  
report either from Mrs. Trayner or Miss Nelles,  
would you?

5

6

A. No.

7

8

Q. Nor from members of your own  
team?

9

A. No.

10

Q. All right. Do you recall then  
who informed you that the children had died?

11

12

A. Members of my team and  
Mrs. Trayner and Miss Nelles.

13

14

15

Q. Would the report that you  
had received on August 4th have included a reference  
to the children who died in your absence?

16

A. I believe there was reference  
made to them, yes.

17

18

19

20

21

Q. All right. When you discussed  
these deaths with members of your own team, was  
there any concern expressed regarding the cause of  
death of any of the four? That is Taylor, Dawson,  
Hoos and Turner.

22

23

A. There was concern about  
Amber Dawson.

24

25

Q. What was the nature of the





1  
2  
3 concern?

4 A. As to the cause of death.

5 Q. Do you recall specifically  
6 who you discussed the matter with amongst your own  
7 team members?

8 A. No, I don't.

9 Q. Was it suggested to you that  
10 the cause of her death had really not been resolved?

11 A. Yes.

12 Q. Was there any uncertainty or  
13 concern expressed regarding that child's death other  
14 than with respect to its cause?

15 A. No. Aside from that there  
16 had been four deaths within that short period of  
17 time. There was concern about that as well.

18 Q. Well, apart from Amber Dawson  
19 did any member of your own team express any concern  
20 to you regarding the cause of death of the other  
21 three?

22 A. No. Not that I recall now.

23 Q. Was there discussion of that  
24 kind, for example, with respect to David Taylor?

25 A. No, I don't believe there was.

Q. I'm sorry.

A. I don't believe there was, no.







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Q. Did there seem to be concern about the cause of death in Lillian Hoos' death?

A. No, not that I recall.

Q. You have told us you discussed these deaths as well with Mrs. Trayner and Miss Nelles?

A. Yes.

Q. Do you recall where you did that?

A. It was some time during the day.

Q. That is on August 4th --

A. Yes.

Q. -- when you came in?

A. Yes.

Q. Did either of those two women express concerns to you as to the cause of death of any of these four children?

A. Again Amber Dawson.

Q. And what concerns did they express?

A. The same thing: the cause of death.

Q. Do you recall who expressed the concern? Were you talking to them both at the same time or were you talking to them individually?





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A. They both were concerned. I was talking to them at the same time.

4

5

6

Q. Again was any concern expressed by either of those two women concerning the cause of death of David Taylor?

7

A. Not that I recall, no.

8

9

10

Q. Was it suggested at any time during any of the discussions you had regarding these children that digoxin may have been involved in the death of Amber Dawson?

11

A. No.

12

13

14

Q. Was it suggested that toxicity from any drug may have played a part in that child's death?

15

A. No.

16

17

Q. Again with respect to David Taylor?

18

A. Not that I recall, no.

19

Q. So can we deal now with David Taylor?

20

A. Okay.

21

22

23

24

25

Q. During those discussions that you held with your team members and with Mrs. Trayner and Miss Nelles was there any discussion that toxicity from any drug may have played a part in





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that child's death?

A. Not that I recall.

Q. Any discussion with respect  
to the possible involvement of digoxin?

A. No.

Q. Do you recall seeing  
Dr. Izukawa when you came back to work on the 4th  
of August?

A. No, I don't.

Q. Did you discuss these deaths  
with any of the cardiologists in the unit?

A. No.

Q. Did you discuss them with  
Mrs. Costello?

A. No, I don't believe I did.

Q. Did you discuss them with  
Mrs. Radojewski, the head nurse on 4A?

A. No.

Q. By the time you came back on  
the 4th, Ms. Bell, there had been seven deaths  
in these two wards. I take it you were aware both  
as to the identify of the children who died and  
as to the fact they had died?

A. Yes.

Q. Did the fact that there had been







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seven deaths in these wards in approximately five weeks cause you concern?

A. Yes.

Q. Were you aware at that time that most of them had taken place on Ward 4A in the early hours of the morning?

A. I believe I was aware of it, yes.

Q. Were you also aware at that time that most of these deaths had taken place while members of Phyllis Trayner's nursing team had been on duty?

A. Yes.

Q. Did you regard that as significant?

A. No.

Q. Did the fact that these deaths were taking place at night and in the presence of the same nursing team cause you to discuss these matters with Mrs. Costello or did it spark any discussions with Mrs. Costello of which you are aware?

A. Not at that time, no.

Q. When you came in on the 4th were you made aware of any discussions that had





1  
2 been held with any of the cardiologists by  
3 Mrs. Costello or Mrs. Radojewski, the head nurses?

4 A. No.

5 Q. To the best of your knowledge  
6 were the cardiologists connected with those wards  
7 or any of them aware that these deaths were mostly  
8 occurring at night and in the presence of the same  
9 members of the same nursing team?

10 A. I don't know if they were  
11 aware of it or not.

12 Q. Do you recall in the discussions  
13 that took place concerning Amber Dawson, Ms. Bell,  
14 being informed of or hearing of any difficulties  
15 that had arisen during these resuscitation efforts  
16 undertaken with respect to that child?

17 A. I don't recall what the  
18 concerns were.

19 Q. Did any of the nurses on your  
20 own team or any of the nurses from 4A ever indicate  
21 to you that there had been a disagreement arise  
22 amongst the nurses who were in attendance at that  
23 resuscitation as to the procedures which should be  
24 followed?

25 A. Not at that time.

Q. Did you subsequently learn





1

2

of that?

3

A. Yes.

4

Q. When was that?

5

A. I don't know. I can't place

6

a date.

7

Q. Can you help me was it into

8

the fall? Was it that summer?

9

A. It was that summer.

10

Q. And what specifically were

11

you informed of in that regard? What were you told  
had happened?

12

A. Well, we had felt there was

13

a problem with - in our point of view that there was

14

a problem with assessment of a situation or calling

15

a Code 25 and when it was done. Basically the

16

assessment of the situation.

17

Q. All right. Can you help

18

me specifically as to what you learned had happened

19

A. I can't think of anything

20

in particular.

21

Q. Well, perhaps I am not under-

22

standing.

23

You told me that you thought that

24

summer you learned of the problem that had arisen

25





1  
2 during the resuscitation of Amber Dawson. Did that  
3 centre around the calling of a Code 25?

4 A. Pardon?

5 Q. Did centre around the calling  
6 of a Code 25?

7 A. I don't know if it was with  
8 regards to Amber Dawson. I can't place when our  
9 concern was arisen.

10 THE COMMISSIONER: I'm sorry, you  
11 can't?

12 THE WITNESS: I can't place when  
13 our concerns came about.

14 THE COMMISSIONER: Yes, but it was  
15 about Amber Dawson?

16 THE WITNESS: I wasn't sure if it  
17 was or not, no.

18 MS. CRONK: Q. All right. Perhaps  
19 I have not understood then. I had thought you  
20 said a moment ago that at some point during the  
21 summer you did learn of a problem that arose during  
22 the resuscitation of Amber Dawson.

23 Do I have that correctly?

24 A. No, no.

25 Q. Did you at any stage learn  
specifically or hear of a problem that had arisen







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Bell, dr.ex.  
(Cronk)

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or a disagreement that had arisen during the arrest  
and resuscitation of that child?

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A. No.

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Q. Can you help me, please, what concern regarding Code 25s were you just referring to?

A. There was a concern about assessing and sort of the ability to assess whether it was a Code 25 or not and the action taken.

Q. Who had this concern?

A. Myself and the members of my team and the members of Phyllis Trayner's team.

Q. Can you help me as to the nature of the concern that you had in the sense of whether or not it involved your own team members?

A. It involved my team members if they were involved with a Code 25.

Q. In what way did it involve your own team members?

A. If they were present.

Q. Was it thought by you at the time, Ms. Bell, that Code 25s were being called too early or too late or were not being considered when they should have been?

A. At one point we thought they were being called too early.

Q. Who did you, as the team leader on 4B, think was calling Code 25s too early?

A. Phyllis Trayner.





J2

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Q. Do you recall that that arose  
in the context of any specific deaths or Code 25s  
or arrests?

A. It had occurred two times  
but I don't know which children it had occurred with  
when we were concerned.

Q. You say it occurred two  
times. What occurred two times?

A. That CPR was initiated per-  
haps too soon.

Q. By CPR, you mean cardio-  
pulmonary resuscitation?

A. Yes, I do.

Q. Does that necessarily involve  
the calling of a Code 25?

A. Yes, it would.

Q. So then in two situations,  
if I understand you correctly, it was thought a Code  
25 had been called earlier than perhaps it should  
have been?

A. Yes.

Q. You do not recall which  
children were involved?

A. No, I don't.

Q. Was that a matter that you







J3

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2

discussed specifically with Mrs. Trayner?

3

4

A. I don't believe it was discussed specifically with her.

5

6

Q. Was it a concern with respect to any other nurse calling Code 25s perhaps too early other than Mrs. Trayner?

7

8

A. No.

9

10

Q. Did someone on either 4A or 4B express a concern about that directly to you?

11

12

A. The nurses on the 4A team, on Phyllis Trayner's team, and on my team as well.

13

14

Q. Expressed a concern to you?

15

16

A. Yes.

17

18

19

Q. As best you can recall it, do you know when those concerns were expressed?

20

21

22

23

24

25

A. I believe at the beginning of August, early August.

Q. You mentioned as well a concern about the time to assess, if I wrote your language down correctly, the time to assess the situation. Can you help me with what you meant by that?

A. That would go along with initiating CPR too soon, instead of taking time to assess what type of heart rate you had and the irregularity of the heart rate and the strength of





Bell  
dr.ex. (Cronk)

1  
J4 2 the heart rate, rather than just looking at the  
3 monitor and initiating a CPR.

4 Q. Was there one or more  
5 individuals who complained of this particular problem  
6 more than others?

7 A. Susan Nelles did.

8 Q. Did you discuss it directly  
9 with her?

10 A. With Susan? Yes.

11 Q. Did she come to you to talk  
12 about this?

13 A. Or I went to her, one or the  
14 other.

15 Q. As best you can recall it  
16 how did you first hear of the problem?

17 A. Well we were involved during  
18 the arrest so it would be after it had occurred, the  
19 two times.

20 Q. As best you can recall it,  
21 did that discussion with Susan Nelles take place over  
22 the summer?

23 A. Yes, it did.

24 Q. But you can't be more specific  
25 as to when it occurred?

A. No, I'm sorry.





Bell  
dr.ex. (Cronk)

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J5 2 Q. At any point, bearing in mind  
3 what you have just said about difficulties concerned  
4 with the calling of a Code 25 and commencing of  
5 cardiopulmonary resuscitation, at any point was it  
6 suggested that a problem of that kind had arisen  
7 during the cardiac arrest and death of David Taylor,  
8 Amber Dawson, Lillian Hoos or Philip Turner?

8 A. No.

9 Q. You don't have any recollection  
10 one way or the other?

11 A. No, I don't.

12 THE COMMISSIONER: What was the nature  
13 of the complaint? What was the nature? Did the  
14 children die, the children for whom Phyllis Trayner  
15 is alleged to have called the 25 too soon?

16 THE WITNESS: They did.

17 THE COMMISSIONER: They died?

18 THE WITNESS: Yes.

19 THE COMMISSIONER: Why would there be  
20 a complaint about calling it too soon?

21 THE WITNESS: Just in the fact that she  
22 was not assessing it and that if you do have a heart  
23 beat and it is fairly strong and if you do initiate  
24 CPR you could --

25 THE COMMISSIONER: Kill the child?





Bell  
dr.ex. (Cronk)

J6

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THE WITNESS: Not necessarily -- no, you wouldn't kill the child. Obviously, there is difficulty but something else could be done. What could be done, you could get a doctor up and either give medications or something else could be done.

THE COMMISSIONER: A doctor comes with this team, doesn't he?

THE WITNESS: Yes. That was our concern at the time.

THE COMMISSIONER: I understand it was your concern, but I really don't quite understand what the concern was. Is it the concern that if you call the 25 too soon, start this cardio-pulmonary resuscitation too soon, that will do some harm to the child?

THE WITNESS: It could. You are not allowing the child to recover on its own. A child, its heart rate could drop and it could become irregular but then it could recover as well. I mean there is a certain point that you would definitely call but we felt there was more time needed to assess.

MS. CRONK: Q. Was it as well, Ms. Bell, a situation where those nurses who were involved had a difference of opinion as to the appropriate time when to call the Code and some thought it should







1  
J7 2 be called sooner and some thought it should be  
3 called later?

4 A. I believe it was a difference  
5 of opinion, yes.

6 Q. To the best of your recol-  
7 lection in the two instances when this problem did  
8 arise, did the two children involved in fact die?

9 A. Yes, they did.

10 Q. And that was after presumably  
11 the Code 25 had been called too early, at least the  
12 suggestion was it was called too early?

13 A. Yes.

14 Q. But even though a Code 25  
15 had been called and the resuscitation team arrived,  
16 the child in fact did not recover and was pro-  
17 nounced dead in both cases?

18 A. Yes.

19 Q. Apart from those two instances,  
20 that is the debate, if I can describe it that way,  
21 as to the appropriate time to take to assess a  
22 child's condition and the difference of opinion  
23 concerning when a Code 25 should be called, did you  
24 ever learn at any time of any other incident -- I'm  
25 sorry, of any incident that arose during the course  
of the resuscitation of David Taylor or Amber Dawson





1  
J8 2 that caused difficulty for the nurses who were in  
3 attendance?

4 A. Not that I know of, no.

5 THE COMMISSIONER: Was it David  
6 Taylor and Amber Dawson, were they two you were  
7 concerned with?

8 THE WITNESS: No, they were not;  
9 not my concern anyway.

10 THE COMMISSIONER: But the concern  
11 that Susan Nelles had about the calling too soon?

12 THE WITNESS: It could have been, yes.

13 MS. CRONK: Q. Do you recall one  
14 way or the other?

15 A. No, I don't.

16 Q. Apart from that you do not  
17 have any recollection of any particular problem  
18 being drawn to your attention and the suggestion  
19 being made that a problem had arisen during the  
20 resuscitation of those two children?

21 A. Not that I recall, no.

22 Q. After you had returned from  
23 holiday and were back on duty at the Hospital,  
24 Dion. Shrum died on August 9th at 7:45 p.m. in the  
25 evening on Ward 4A. The child had been admitted on  
August 8th and as I understand it you worked the





J9

1

2

long day shift on that day, do I have that  
correctly?

3

4

A. Yes, that is correct.

5

6

Q. Did you have occasion to  
see Dion Shrum when the child was admitted on  
August 8th?

7

8

A. No.

9

Q. You did not see the child?

10

A. No, I did not see the child.

11

Q. Did you as well work on  
August 9th, the 12-hour long day shift?

12

A. Yes, I did.

13

Q. And that was the day when the  
child in fact died?

14

A. Yes.

15

16

Q. Did you have occasion to  
see the child at any time on August 9th?

17

A. Just during the arrest.

18

19

Q. When you came on duty that  
day on the 9th, I take it you were aware that there  
had been a new admission the day previous?

20

A. I was aware, yes.

21

22

Q. Were you also aware as to  
what his condition was felt to be at the start of your  
shift on the 9th of August?

23

24

25







1  
J10 2 A. I don't know if it was made  
3 known to me at the start of the shift, but towards  
4 the end of the shift I knew that this child's  
5 condition was not very stable.  
6 Q. And how did you learn that?  
7 A. The ICU resident came up to  
8 the ward and was assessing him on whether or not  
9 he should be transferred to the ward, and I believe  
10 on the request of Phyllis Trayner and Susan that he  
11 should be going to ICU.  
12 Q. Who was the ICU Resident who  
13 came to the ward?  
14 A. Dr. O'Toole.  
15 Q. Do you recall when he came to  
16 the ward?  
17 A. I don't recall the exact time.  
18 I believe it was around 5:30, six o'clock in the  
19 evening.  
20 Q. Prior to Dr. O'Toole arriving  
21 on the ward, had you had any discussion either with  
22 Mrs. Trayner or Miss Nelles concerning the condition  
23 of this child?  
24 A. Our evening supervisor had  
25 come up to the ward and was -- she had wanted to  
rearrange the staffing and our concern for him was





1  
J11 2 there and we felt that she should not change the  
3 staffing and leave it as it was because we were not  
4 that well staffed to begin with, and we felt that he  
5 needed to be observed and therefore we needed the  
6 staff. She had gone off the ward telling us that  
7 she would get back to us about what she was going to  
8 do with the staffing, but she never did because he  
9 arrested.

9 Q. This child was on 4A as I  
10 understand it?

11 A. Yes, he was.

12 Q. And you were on the day shift  
13 on the 9th and the child died at 7:45 p.m. in the  
14 evening?

15 A. That's right.

16 Q. When then was the evening  
17 supervisor on the ward seeking to change the duty  
18 roster?

19 A. I believe around five or six.

20 Q. At that time were the changes  
21 proposed affecting the 4A nurses as well as the 4B  
22 nurses?

23 A. That is right.

24 Q. Was it at that time that you  
25 had a discussion concerning this child's condition?





1

J12 2

A. Yes, it was.

3

Q. What were you informed at that  
time?

4

5

A. It was suggested to us that  
she was going to take an RN, whether it be an RN  
from the team or one of the team leaders, I don't  
recall which one, and what we would do we would  
combine and have one team leader for the two wards.

6

7

8

9

10

11

Q. In the course of discussing  
that proposed staff change, did Dione Shrum's  
condition come up?

12

A. Yes.

13

Q. Were you present when it was  
discussed?

14

15

A. Yes.

16

17

Q. What did you understand his  
condition to be at that time, 5:30 or six o'clock  
in the evening?

18

19

A. That his condition needed  
close attention; we needed the staff to cover this  
child.

20

21

Q. Who told you that?

22

A. Phyllis Trayner, I believe.

23

Q. Had you seen the child at  
any point at that time yourself?

24

25





Bell  
dr.ex. (Cronk)

1

J13 2

A. No, I hadn't.

3

4

Q. So far as you were aware was this child's condition considered critical? Was there a thought that he might die?

5

6

A. It was considered critical, yes.

7

8

Q. Was he at that point regarded as one of the seriously-ill patients on the ward?

9

A. Yes.

10

11

Q. Did the staff change that was being proposed by the evening supervisor in fact take place?

12

13

A. No, it did not.

14

15

Q. Dion Shrum as far as you were aware at that stage, was he on constant nursing care or shared nursing care?

16

17

A. Perhaps shared care, but I can't be sure.

18

19

Q. You have told us that Dr. O'Toole came to the ward and I believe you said you thought it was around 5:30 or 6:00 p.m. in the evening.

20

21

A. Yes.

22

23

Q. Were you present when Dr. O'Toole observed the child?

24

25







J14 1  
2 A. Not when he observed the  
3 child, no.  
4 Q. Can you help me again as to  
5 how it came about that Dr. O'Toole in fact came to  
6 the ward?  
7 A. I believe Mrs. Trayner had  
8 called him. Either Mrs. Trayner or Susan Nelles  
9 had called him.  
10 Q. For what reason?  
11 A. To assess this child.  
12 Q. For the purposes of a potential  
13 transfer to the Intensive Care Unit?  
14 A. Yes.  
15 Q. And while Dr. O'Toole was  
16 there did you participate in the discussions con-  
17 cerning this child?  
18 A. I participated in some of  
19 the discussion.  
20 Q. Did you have a chance to  
21 actually see the child yourself?  
22 A. No, I didn't.  
23 Q. Was the child in fact trans-  
24 ferred to the Intensive Care Unit?  
25 A. No.  
Q. Do you recall Dr. Freedom





1  
J15 2 being present on the ward at any time when Dr.  
3 O'Toole was there or while either Mrs. Trayner or  
4 Miss Nelles were suggesting this child should be  
5 transferred to the Intensive Care Unit?

6 A. Not that I recall, but he  
7 could have been, I don't know.

8 Q. Do you recall when Dr.  
9 O'Toole left the ward?

10 A. It was before his arrest.

11 Q. We know a Code 23 was called  
12 on the child. Prior to that happening I take it  
13 you had not seen the child?

14 A. That is right.

15 Q. What happened when the Code 23  
16 was called?

17 A. Well, the Code 23 would have  
18 been called for the Resident on call and we would  
19 have gone into the room to see the child.

20 Q. Did you personally go into the  
21 room when the Code was called?

22 A. I believe I did.

23 Q. Who was there when you went  
24 into the room?

25 A. I can't recall.

Q. Were you there while the





Bell  
dr.ex. (Cronk)

1  
Jl6 2 resuscitation efforts for the child were undertaken?  
3 A. Yes.  
4 Q. Did you stay until the child  
5 was pronounced dead?  
6 A. Yes.  
7 Q. Did you in the course of  
8 being in the room observe any terminal event or  
9 symptom exhibited by the child which you regarded as  
10 unusual?  
11 A. No.  
12 Q. During the course of the  
13 discussion, after the child had died, was it sug-  
14 gested to you, or in your presence, by any member  
15 of the 4A nursing team or the 4B team that the  
16 cause of that child's death was unknown?  
17 A. The cause of his death was  
18 unknown.  
19 Q. Was it your impression that  
20 the nursing staff including Mrs. Trayner and Miss  
21 Nelles from 4A regarded the timing of his death as  
22 unexpected or unusual?  
23  
24  
25







BmB.jc  
K

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25

A. I don't think it was unexpected because they felt he was ill and was in some imminent danger and that is why they wanted him transferred to the I.C.U. So, I don't believe they were surprised.

Q. Do you know why the child was not transferred to the Intensive Care Unit?

A. Offhand I don't, no. It could have been availability of space in I.C.U. or perhaps Dr. O'Toole felt that his condition didn't necessitate it, I don't know.

Q. Was it your impression when you saw Dr. O'Toole that he felt the child should be transferred to the Intensive Care Unit or that it was not necessary?

A. That it wasn't necessary.

Q. All right. Could I ask you to look at the medical record for this child as well.

A. Okay.

Q. Mr. Registrar, if you could show Ms. Bell Exhibit 53.

I would ask you to turn to page 50 if you would, please, of the medical chart. There is a list at that page, Ms. Bell, of the various medications that were administered to this child during the resuscitation effort. Do you recognize the handwriting?





K.2

1

2

A. I'm sorry, page 50?

3

Q. Page 50.

4

THE COMMISSIONER: Are you sure it is  
page 50?

5

6

MS. CRONK: I'm sorry, page 43 in the  
blue numbering, page 43.

7

THE WITNESS: I have it.

8

9

MS. CRONK: Q. Do you recognize the  
handwriting?

10

A. Yes.

11

Q. Whose is it?

12

A. Mine.

13

14

Q. Was it part of your job during  
the resuscitation of this child to note the medications  
that were administered to him?

15

A. Yes, it was.

16

17

Q. Was that the normal role which  
you assumed in an arrest if you arrived in a room  
when an arrest had been called?

18

19

A. Not necessarily.

20

21

Q. Who would determine whose job  
it was to record the medications administered to the  
child?

22

23

A. Usually the team leader on that  
side or whoever was in charge.

24

25





K.3

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2

3

4

Q Well, in this case who was in charge in the room when you entered it when the Code 22 was called?

5

A That would be Phyllis Trayner.

6

Q Were you requested by anyone to record the medications?

7

8

A I don't recall if I was requested or not. I believe nobody was doing it, so, I did it.

9

10

11

12

Q Did you at any time during that day shift, Ms. Bell, observe anyone administering a medication of any kind to this child prior to the Code 23 being called?

13

A No.

14

15

Q Was it ever suggested to you at any time that this child may have received a medication that was not prescribed for him?

16

A Not that I'm aware of, no.

17

18

19

20

Q Was it suggested at any stage after his death whether it be by the 4A/4B nurses or by any of the cardiologists that digoxin toxicity may have been involved in the child's death?

21

A Not that I am aware of, no.

22

Q You don't recall any discussion in that regard?

23

A No, I don't.

24

25





K.4

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25

Q. The next child to have died when, according to my understanding you were on duty, Ms. Bell, was Paul Murphy. He died on August 23rd, 1980 at 4:45 a.m. - I am sorry, at 10:28 in the evening, I'm sorry.

A. That's right.

Q. And according to the summary sheet you were on duty on the 12-hour long night on August 23rd, is that correct?

A. Yes, I was.

Q. Do you recall seeing this child at any time when you came on duty that night?

A. Just at the time he died.

Q. You didn't see him prior to that?

A. No, I don't believe I did.

Q. He had been a patient at the Hospital on and off for a considerable length of time. Was he as a patient known to you before that day?

A. Yes, he was.

Q. What did you understand Paul Murphy's condition to be when you reported to work on the 23rd?

A. Well, he was not doing very well at all and that he was probably going to die.

Q. How did you learn that?







K.5

1

2

A. I believe Mrs. Trayner told me.

3

Q. This child was a patient on

4

Ward 4A, was he not?

5

A. Yes.

6

Q. Do you recall specifically

7

Mrs. Trayner discussing his condition with you when  
you came on duty that night?

8

A. I believe we did, yes.

9

Q. Was he regarded in your view at

10

that time as a seriously ill patient?

11

A. Yes, he was.

12

Q. How did it come about that you

13

attended in his room at the time of the arrest?

14

A. Mary Cooney was looking after him

15

and she had called out and I had gone down to the room.

16

Q. Do you recall when that happened?

17

A. Not the exact times, just prior

to his death.

18

Q. Was a resuscitation effort

19

undertaken in respect of this child?

20

A. No.

21

Q. Was there a 'do not resuscitate'

order in place?

22

A. Yes, there was.

23

Q. Were you aware of that at the

24

25





K.6

1

2

beginning of the shift?

3

A. I believe I was.

4

Q. Had it been in place for some

5

time?

6

A. I don't know.

7

Q. What was the child's condition

8

when you entered the room when Ms. Cooney called out?

9

A. He was very cyanosed, his

10

respirations were absent, or he would have the

11

occasional respiratory effort, that's it.

12

Q. Who else was in the room when

13

you entered it?

14

A. Dr. Wilkinson and Mary Cooney and

15

myself.

16

Q. Did you remain in the room until

17

the child was pronounced dead?

18

A. Yes, I did.

19

Q. Was any effort made at that

20

time in light of the 'do not resuscitate' order to

21

attempt to have the respirations of the child resumed

22

or to stimulate cardiac activity?

23

A. He was given oxygen.

24

Q. And did that assist?

25

A. I think it made him more

comfortable.

26

27





K.7

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24

25

Q Did it assist however in  
allowing the child to resume normal respirations or  
normal cardiac activity?

A No, he didn't resume normal ...

Q Did he in fact return to a  
stable condition at all following your entry to the  
room?

A No.

Q After Paul Murphy's death,  
Ms. Bell, I take it that you would have discussed his  
death amongst nurses on 4B and 4A as you had the other  
deaths?

A Yes.

Q Aside from the expected and  
natural sorrow that accompanied the child's death,  
was it ever suggested to you at any time from any of  
the nurses or any member of the medical staff that  
intoxication from any drug may have played a part in  
this child's death?

A No.

Q Was toxicity with respect to  
digoxin ever suggested in connection with this child  
in your presence?

A Not in my presence, no.

Q Did you, based on what you







K.8

1

2

3

4

observed while you were in the room during the arrest,  
regard any of his terminal events or terminal symptoms  
as being unusual?

5

A. No.

6

Q. Had you cared for Paul Murphy  
yourself prior to that time?

7

A. Yes, I had.

8

9

Q. Had he been intermittently a  
patient on 4B?

10

11

A. I can't recall if he was a  
patient on 4B but he was a patient on 5A.

12

13

Q. Did you regard his condition on  
the 23rd before he died as different from what it had  
been in the days preceding that?

14

15

A. He was much worse.

16

Q. And was he in your view  
deteriorating during the course of that shift?

17

18

A. I hadn't seen him at the  
beginning of the shift but from when I had seen him  
before he was deteriorating, yes.

19

20

Q. At any time was it ever  
suggested to you by any members of the nursing staff,  
whether it is your own team members or Mrs. Trayner  
or Ms. Nelles or anyone else connected with the 4A  
nursing staff, that the cause of that child's death  
was unknown?

21

22

23

24

25





K.9

1

2

A. No.

3

Q. Was there any uncertainty as to

4

why the child had died insofar as you were aware?

5

A. No.

6

Q. Why was it considered that he

had died?

7

A. Because of his cardiac anomalies.

8

Q. Following the death of Paul

9

Murphy, the very next night ---

10

A. It was the same night.

11

Q. The same night?

12

A. Yes.

13

Q. On the 24th?

14

A. Yes.

15

Q. Antonio Velasquez died?

16

A. It was the same night.

17

Q. I'm sorry?

18

A. It was the same shift.

19

MS. CRONK: I would like to take our

20

break now, sir, before I start on Velasquez.

21

THE COMMISSIONER: Well, I think so.

22

MS. CRONK: That's fine, sir.

23

THE COMMISSIONER: It will be a little

longer, will it not?

24

MS. CRONK: Yes.

25

THE COMMISSIONER: Until 2:30.

--- Luncheon recess.





BmB.jc  
AA

1  
2 --- Upon commencing:

3 THE COMMISSIONER: Yes, Miss Cronk.

4 MS. CRONK: Mr. Registrar, would you  
5 show Ms. Bell if you would, please, Exhibit 117 again,  
6 that's the medical record of Laura Woodcock.

7 Q Ms. Bell, I would ask you to  
8 turn if you would, please, to page 33 at which is  
9 set out part of the final autopsy report on Laura  
10 Woodcock.

11 A. Yes.

12 Q Just to return to this child  
13 before we move on. You will recall that earlier this  
14 morning you told us that according to your best  
15 recollection when you saw the autopsy report or  
16 learned the autopsy results on Laura Woodcock, you  
17 felt that the cause of her death had been explained.  
18 Did I understand your evidence correctly?

19 A. Yes.

20 Q And I draw your attention, feel  
21 free to look at any portion of the autopsy report you  
22 wish to, but I draw your attention particularly to  
23 the last paragraph at page 33 and I would ask you to  
24 read it. I suggest to you that in summary, according  
25 to the autopsy report that was prepared, the exact  
cause of this child's death remained unclear after





AA.2

1

2

the final autopsy report had been completed?

3

A. Yes.

4

Q. All right. Is there anything that you now recall as having come forward from the post mortem conducted on this child which in your mind satisfactorily explained this child's death?

7

A. No.

8

Q. Well, was there anything outside the autopsy report itself that was told or communicated to you which suggested that the autopsy had identified and isolated a cause of death for this child?

12

A. No, there is no exact cause.

13

Q. All right. And that was reflected by the final paragraph of the autopsy report?

14

A. Yes.

15

16

17

18

19

20

Q. Could we move then now to the case of Antonio Velasquez. This child died on August 24th at 4:25 a.m. on Ward 4A; later on the same shift that Paul Murphy had died. As I understand it you were on duty, as you were with Paul Murphy, during that entire long night shift?

21

A. Yes, I was.

22

23

24

25

Q. Were you aware when you reported for duty on August 23rd for the night shift that it was intended that Antonio Velasquez be sent home?







AA.3

1

2

A. No, I did not know.

3

Q. Did you in fact know what his

4

condition was when you reported for work that night?

5

A. No, I didn't.

6

Q. Do you recall discussing his

7

condition with Phyllis Trayner who was the team leader  
on Ward 4A that evening?

8

A. No.

9

Q. To the best of your knowledge,

10

was he one of the children listed on the seriously ill

11

list for the use of the night supervisors that evening?

12

A. Not that I am aware of but it

13

could have been.

14

Q. Did you have occasion personally

to see the child during that night shift?

15

A. No, not until he actually

16

arrested or was having problems.

17

Q. Well, when was the first time

18

that you saw the child?

19

A. Just prior to his arrest.

20

Q. Do you recall now what time of

the morning or evening that was?

21

A. It was after midnight but I don't

22

know the exact time.

23

Q. How did it come about that you

24

saw the child then?

25





AA.4

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A. I was at the desk and Mary

Cooney was looking after this patient and she came out to the desk and she had a concern about him and Phyllis Trayner wasn't around, she was in the bathroom. So, I went to assess what was wrong.

THE COMMISSIONER: I'm sorry, who was looking after him?

THE WITNESS: Mary Cooney.

THE COMMISSIONER: Oh, yes. And she was on the Trayner team I take it?

THE WITNESS: No, I don't think so. She was on 4A but I don't know if she was on her team specifically or not.

THE COMMISSIONER: I meant she was ...

THE WITNESS: On that night, yes.

THE COMMISSIONER: On that night.

THE WITNESS: Yes.

THE COMMISSIONER: Phyllis Trayner was the team leader?

THE WITNESS: Yes.

MS. CRONK: Q. Could we look for a moment at the 4A assignment book, that is Exhibit 32C, Mr. Commissioner, Tab 89, for August 23rd. It is Tab 89, Ms. Bell.

A. 89?





AA.5

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2

Q. 89. It is page 115 of that tab.

3

A. I'm sorry, I can't get it.

4

Q. I'm sorry, you've got the wrong

5

book. Can we have 32C, Mr. Registrar.

6

A. All right.

7

Q. Tab 89, page 115.

8

A. Page 115?

9

Q. 115. It is the entries for the

long night shift on Ward 4A for August 23rd.

10

A. Yes, I have it.

11

Q. All right. As I read the

12

entries for the long night shift, Ms. Bell, Mrs.

13

Trayner, then Miss Morrin, was on duty and was the  
nurse in charge?

14

A. That's right.

15

Q. Sui Scott was on duty and had

16

three children in Room 418?

17

A. That's correct.

18

Q. Mrs. Christie was ill and was

19

not on duty?

20

A. Right.

21

Q. Ms. Nelles was not on duty on 4A?

22

A. No.

23

Q. And Ms. Cooney was on duty and

had one child in Room 421, two in 418 and an

24

25







AA.6

1

2

unspecified number in 423 but that appears to be

3

Paul Murphy?

4

A. Yes.

5

Q. Can you help me please as to how

6

you can determine if you can from these entries whether

7

it was Mrs. Scott or Ms. Cooney who had responsibility

8

for Velasquez in Room 418?

9

A. The children are listed next to  
Mrs. Scott's name, Volk - I can't read the next name.

10

Q. And the names listed do not

11

include that of Velasquez?

12

A. No.

13

Q. And it is your recollection that

14

Ms. Cooney approached you at the nursing station?

15

A. Yes, she did.

16

Q. What was the concern she then

17

expressed to you regarding Antonio Velasquez' condition?

18

A. She was concerned that he was

19

very lethargic and he was very difficult to arouse and  
his heart rate I believe was - he was bradycardic.

20

Q. What did you do as a result of

21

her having spoken to you?

22

A. I went into the room and I

23

assessed him as well and then I went out to call the  
resident on call, Dr. Wilkinson.

24

25





AA.7

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2

3

Q. Who was in the room at the time  
you entered it?

4

A. Mary Cooney.

5

Q. Anyone else?

6

A. I don't know if Phyllis had  
returned by then or not, I'm not sure.

7

Q. Was Mrs. Scott there?

8

A. I don't believe she was.

9

Q. All right. You then called  
Dr. Wilkinson?

11

A. Yes, I did.

12

Q. Did you return to the nursing  
station to do so?

13

A. Yes, I did.

14

Q. How long after your call did  
Dr. Wilkinson arrive?

16

A. It was only a few minutes  
before he arrived, maybe two minutes.

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Q. Would you look at Antonio Velasquez' medical chart, please, page 48.

A. Yes, I have it.

Q. Do the nursing notes at page 48 help you to determine the time at which you called Dr. Wilkinson?

A. It would be 0300.

Q. All right. And I take it it would have been shortly before that when Miss Cooney approached you at the nursing station?

A. Yes.

Q. In the course of describing to you her concerns about the child's condition did Miss Cooney also indicate to you what the child's condition had been earlier in the evening?

A. She had stated that he had received an analgesic earlier.

Q. Did she describe to you whether or not his condition at three in the morning had worsened from that which had existed earlier in the evening?

A. Yes. Obviously it had worsened; that is why she was concerned and got someone.

Q. What did Dr. Wilkinson do when





1  
BB2 2 he arrived?

3 A. He tried to arouse the  
4 patient and he couldn't. Then he asked for some  
5 narcan.

6 Q. Were you aware at that point  
7 of the medications that had been administered to  
8 the child earlier that evening and on that day,  
9 August 23rd?

10 A. The only one that I was  
11 aware of was the Codeine.

12 Q. All right. And how were you  
13 aware that Codeine had been given?

14 A. Mary Cooney had stated that  
15 he had received Codeine earlier in the evening for  
16 discomfort.

17 Q. After you called Dr. Wilkinson,  
18 did you return with Miss Cooney to the child's room?

19 A. Yes, I did.

20 Q. You were there in the room  
21 when Dr. Wilkinson arrived?

22 A. Yes.

23 Q. Were you there throughout  
24 the efforts that were taken to resuscitate the child  
25 until he was pronounced dead?

26 A. Yes, I was.







BB3

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Q. After Dr. Wilkinson arrived in the room then could you help me as to what he did first or what happened first with respect to the child?

A. He did an assessment of his own when he arrived in the room and asked what had occurred. He was told about the Codeine that he had gotten earlier. He had listened to his heart rate and he tried to arouse him himself. And then he felt that he was difficult to arouse and that perhaps narcan was needed, and then he asked for the narcan.

Q. Were you there when Dr. Wilkinson administered the narcan?

A. I was.

Q. The progress notes of the child indicate that there were two doses of narcan administered.

A. Yes.

Q. Were you there while both doses were administered?

A. Yes, I was.

Q. Will you turn with me, please, to page 83 of the chart. This is the medication and treatment record for Velasquez throughout the entire night shift.





1  
2                   Would you help me, please, Ms. Bell,  
3 by outlining what medications are recorded as having  
4 been given earlier prior to Dr. Wilkinson's arrival.  
5 Perhaps you could start from the start of the night  
6 shift that night on the 23rd.

7                   A.       It looks like at -- it is  
8 either 2030 or 2130, it looks like Tempra was  
9 given.

10                  Q.       All right. And that was given  
11 by whom?

12                  A.       Phyllis Morrin.

13                  Q.       And what else was given?

14                  A.       I think that is all.

15                  Q.       Was Mandol given?

16                  A.       Oh, yes.

17                  Q.       At 2400 hours on the 23rd?

18                  A.       Yes. Right.

19                  Q.       That was given by Miss Morrin  
20 again?

21                  A.       Yes.

22                  Q.       There is an indication as well,  
23 is there not, that Codeine 8 mg. was given orally?

24                  A.       I can't see the time.

25                  Q.       All right. Well, to assist  
you with the time, could you turn to page 49, the





1

2

progress notes.

3

A. Yes.

4

Q. There is an indication I

5

suggest on the left-hand side of the page that

6

Codeine was given at 2130 in the evening on August

7

23rd.

8

A. Yes, it was.

9

Q. We have then a record of at

10

least three drugs having been given to the child,

11

the Tempra, the Mandol and the Codeine, during the

course of the evening.

12

Other than those drugs to the best of

13

your knowledge was any other medication given to

14

this child during the course of the night shift

prior to the arrival of Dr. Wilkinson?

15

A. Not that I know of, no.

16

Q. And if the entry regarding

17

Codeine and the timing of its administration be

18

right and the timing entry for the dose of Mandol,

19

would you agree that the last recorded medication,

20

the last medication recorded as having been given to

the child was the Mandol given at midnight?

21

A. Yes, it was.

22

Q. You have told us that when

23

Dr. Wilkinson arrived he proceeded to administer two

24

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doses of Narcan.

A. That is correct.

Q. We know that the child then proceeded to full arrest and was unable to be resuscitated.

Did you at any time over the course of the night shift prior to Dr. Wilkinson's arrival observe the administration of any medication to this child by any individual, be it Mrs. Trayner or anyone else?

A. No, I did not.

Q. Was an IV running on the child when you entered the room?

A. I don't recall. I don't know.

Q. Would you look as well, please, again at page 83 of the record, the medication and treatment record. Do you have that?

A. I have it.

Q. On my reading, and I would ask you to confirm whether I am reading this correctly, Ms. Bell, it appears that digoxin, although previously ordered for the child, was discontinued on the 20th and was not reordered or at least not readministered to the child according to the medications recorded as having been given?





1

2

A. That is correct.

3

4

5

6

7

8

Q. At any time after the death of Antonio Velasquez, be it that morning following his being pronounced dead by Dr. Wilkinson or later in the day during any discussions with any members of the nursing staff or any of the cardiologists, was it suggested to you that digoxin may have had any involvement in his death?

9

A. No.

10

11

12

13

Q. Did the question of toxicity, be it from digoxin or any other drug, with the exception of Narcan, arise at all in discussion as to what had caused his death?

14

A. No.

15

16

17

Q. Do you remember any concern being expressed either by the doctors who were present at his arrest or the nurses who were present as to what had in fact caused his death?

18

A. We were unsure of the cause.

19

20

21

22

He was doing reasonably well post-operatively. Afterwards, when they had discussed his case and after they had done the post mortem, they felt it was idiosyncratic reaction to the Narcan. And other than that, that was all.

23

Q. Well, at the time that it

24

25





1

2

happened, did you discuss it with Dr. Wilkinson  
after the child died?

3

4

A. No.

5

6

Q. Was it your impression that  
the other nurses who had been present -- was there  
any other physician present other than Dr. Wilkinson  
before the child was pronounced dead?

7

8

9

A. There was the rest of the  
arrest team. I can't give you any names.

10

11

12

Q. Was it your impression at  
the time that the physicians who were present felt  
that there was a satisfactory explanation for his  
death?

13

14

A. No.

15

16

17

18

19

Q. In your experience as nurse  
both on these wards and prior to joining the staff  
in the cardiology unit at The Hospital for Sick  
Children had you ever before encountered a situation  
where a patient had died apparently from an adverse  
reaction to Narcan?

20

21

22

A. No, not that I know of.

23

24

25

Q. Was that something based on  
your knowledge and experience that was unusual?

A. Yes.

Q. Did you feel once that





1

2

explanation was forthcoming that it satisfactorily  
3 explained this child's death?

4

A. Yes. To a point.

5

6

7

8

Q. In your own mind after it  
had been suggested that he had suffered an adverse  
reaction to Narcan did you have any lingering  
questions as to what in fact may have caused his  
death?

9

10

11

A. I was not very comfortable  
with it, but I didn't really question that the  
Narcan...

12

13

Q. You didn't question that the  
Narcan had caused it?

14

A. That is right.

15

16

17

Q. Well, when was the first time  
that you heard it suggested that the child's death  
could be attributed to an adverse reaction to the  
Narcan?

18

19

20

A. I don't think it was until  
about a week after if that soon after. Not until  
the post mortem had been done and it was discussed  
I believe in the mortality rounds.

21

22

Q. Was it at that time at the  
mortality rounds that it was first raised with you?

23

24

25

A. No, I didn't go to the mortality







1  
2 rounds. I had seen the Minutes from that particular  
3 meeting.

4 Q. And we know that there was  
5 a mortality and morbidity meeting held on September  
6 5th. Is that the meeting to which you are referring?

7 A. I believe so -- no, I was at  
8 that one. It was the one later on I think.

9 Q. September 26th?

10 A. I think so.

11 Q. Prior to that time had it  
12 ever been suggested to you that the cause of the  
13 child's death was an adverse reaction to Narcan?

14 A. No.

15 Q. Did you ever have occasion to  
16 discuss the cause of that child's death with either  
17 Dr. Freedom or Dr. Rowe?

18 A. No, I didn't.

19 Q. Do you recall it being a  
20 matter of discussion amongst Ward 4A and 4B nurses  
21 after the child had died?

22 A. There was a concern, yes.

23 Q. Perhaps we can explore that  
24 further when we come to the mortality meeting of  
25 September 26th. But to the best of your recollection  
after that meeting was held was there continuing





1  
2 concern as to what had caused the child's death?

3 A. I had a concern but I don't  
4 know if anyone else did.

5 Q. And that is, you had that  
6 concern in the face of the suggestion that Narcan  
7 might have caused the child's death?

8 A. Yes.

9 Q. All right.

10 Could we turn then to the case of  
11 Lorette Heywood. She died on September 2nd at  
12 8:30 in the morning on Ward 4A. As I understand it  
13 you worked the long day shift both on September 1st  
14 and on September 2nd; is that correct?

15 A. That is correct, yes.

16 Q. Do you recall seeing this  
17 child on September 1st?

18 A. I had gone in during the  
19 arrest, yes. But not before that.

20 Q. All right. I am talking now  
21 about September 1st --

22 A. Oh, I'm sorry.

23 Q. -- the day before the child's  
24 death. Do you recall seeing her then?

25 A. I don't know. I don't recall.

Q. When you came on duty on





1

2

September 2nd to the best of your recollection what  
was the child's condition at that time?

3

4

A. When I came on?

5

Q. Yes.

6

A. I don't think I was aware of  
her condition at that time.

7

8

9

10

11

12

13

Q. Well, we know that the child  
had been on Ward 4A for a number of days prior to  
her death, and we know that you were on duty on  
September 1st, the day before she died, and as well  
on the day she did die. At any point prior to her  
actually experiencing a cardiac arrest, had it been  
suggested to you that her condition was critical or  
that she was a seriously ill patient?

14

15

A. She was a seriously ill  
patient, yes.

16

17

Q. Had you discussed her case  
with Phyllis Trayner?

18

A. I believe I did, yes.

19

Q. Do you recall doing so?

20

A. Yes.

21

Q. All right. Do you recall when  
that occurred?

22

A. I imagine it was September 1st.

23

Q. Do you remember discussing it

24

25







1  
2 or is it to the best of your recollection you expect  
3 that you did?

4 A. I expect I did on the 1st  
5 because I wouldn't have had time on the 2nd.

6 Q. When you came in to work on  
7 September 2nd, that morning, was she then in  
8 cardiac arrest or did that occur after you had been  
9 on the ward for some time that morning?

10 A. It had occurred after, once  
11 I had started the day.

12 Q. Did you see her before her  
13 cardiac arrest?

14 A. No.

15 Q. When then did you first see  
16 her and how did that come about?

17 A. The cardiac arrest had -- well,  
18 the 25 had been called and I had just gone down there  
19 to see if there was -- if they needed any assistance.  
20 They didn't and I went back to 4B.

21 Q. You were then not in the  
22 room during the arrest and the resuscitation efforts?

23 A. No, I wasn't.

24 Q. It is my understanding there  
25 was a do not resuscitate order in place with respect  
to this child. Does that accord with your recollection?





1

2

A. No, I don't remember.

3

4

Q. After Lorette Heywood died  
(you were on 4B at the time) do you recall any dis-  
cussion amongst the nursing staff as to what had  
caused her death?

5

6

A. No.

7

8

9

10

Q. Did you participate or hear  
of any discussion in which it had been suggested  
that her death had occurred at a time which would  
not be expected by the medical and nursing staff?

11

A. No.

12

13

14

Q. Do you recall any suggestion  
at any time by any member of the nursing staff or  
the medical staff that digoxin may have played a  
role in that child's death?

15

A. No.

16

17

Q. Did the issue of toxicity  
arise?

18

A. No.

19

20

21

22

Q. Did there seem to be, insofar  
as you appreciated the situation, did there seem  
to be a concern amongst members of the nursing staff  
with respect to the circumstances surrounding that  
child's death?

23

A. No.

24

25





1  
2 Q. By September 2nd - that's the  
3 day of Lorette Heywood's death, Ms. Bell - there  
4 had been 12 deaths in combination on Wards 4A/4B  
5 mostly in the early hours of the morning and for the  
6 most part on Ward 4A.

7 Would it be fair of me to suggest  
8 there had never before been as many deaths in such  
9 a short time frame on these two wards?

10 A. Yes.

11 Q. Did the fact that most of  
12 these deaths were occurring at night in the presence  
13 of the same nursing team and that the deaths had  
14 reached 12 by the end of the summer, September 2nd,  
15 cause any particular concern to your nursing team?

16 A. Yes.

17 Q. What was the nature of their  
18 concern?

19 A. The nature of the concern was  
20 why so many children were dying. If there was any-  
21 thing that we could do to prevent this; anything  
22 that we could do during the times. There was a  
23 concern as to the causes of death.

24 Q. Was that concern particular  
25 to any specific children?

A. No.





1

2

Q. Or was it a concern at large?

3

A. No, it was a concern at

4

large.

5

Q. Did the members of your

6

team request you at any time during the latter part

7

of the summer or early fall to hold a meeting with

8

them and with any of the cardiologists to review

these deaths further?

9

A. It was discussed.

10

Q. When was it discussed?

11

A. In August. I don't know --

12

Q. Did they come to you, Ms.

13

Bell, with a specific request that these deaths be

reviewed?

14

A. There was no specific re-

15

quest. There was the concern. The concern was there

16

but no request was made to review the deaths.

17

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Q. Well, we know that there was a meeting to which we referred a moment ago, the mortality and morbidity meeting held on September 5th, 1980 at which some of these deaths were in fact discussed.

A. Yes.

Q. How did you understand that that meeting came about?

A. From our concerns.

Q. Is that your team's concerns, was it nursing concerns, or was it concerns of a particular individual?

A. It was the concerns of my team, the 4A team and everyone on 4A and B.

Q. Did you attend that meeting?

A. Yes, I did.

Q. What did you understand its purpose to be?

A. To help us understand the increase in the number of deaths and perhaps to understand the cause of death as well.

Q. Did you, after the meeting, have occasion to see the Minutes that were kept?

A. Yes, I did.

MS. CRONK: Mr. Registrar, could





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you show the witness please Exhibit 45.

Q. As best as you can recall it, Ms. Bell, were the nurses from your team, or any of the nurses on 4A involved in selecting the cases that were to be discussed at this meeting?

A. No.

Q. Had there been any suggestion that there were particular cases that the nurses wished to be discussed in depth?

A. There could have been but I am not aware of it.

Q. According to the minutes, Ms. Bell, three of the children were discussed, that is Bilodeau, Baby Turner and David Taylor. Do you recall the discussions concerning these children at this time?

A. Yes.

Q. With specific reference to David Taylor, do you recall at any time at that meeting it being suggested that digoxin toxicity may have contributed to his death?

A. Not that I recall, no.

Q. Did you keep notes of this meeting?

A. No, I didn't.





CC3

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Q. Did you notice anyone else  
keeping notes of the meeting?

4

A. No.

5

6

MS. CRONK: Mr. Registrar, could we  
have Exhibit 46 please.

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Q. Ms. Bell, Exhibit 46 is a  
series of handwritten notes kept by one of the  
individuals, Elizabeth Radojewski, who was present  
at the meeting, and I would draw your attention to  
the page that is number 11 in the top right hand  
corner. In the middle of the page in the notes  
there is set out a discussion concerning David  
Taylor, and immediately above the word "postmortem"  
we see this entry:

15

"ECG ST down, depression ? dig toxic."

16

Do you see that?

17

A. Yes, I do.

18

19

Q. Do these notes help you in  
refreshing your memory as to what in fact was  
discussed with respect to David Taylor?

20

21

A. I don't recall it being  
discussed, but I assume it was from this.

22

23

24

Q. I take it then you have no  
recollection as to who might have raised the matter  
at the meeting?

25







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A. No, I have not.

4

Q. Nor as to the nature of the discussion that may have followed?

5

A. No.

6

7

Q. When you left the meeting, Ms. Bell, in your own mind were you satisfied that a satisfactory explanation for the cause of that child's death had been advanced?

8

9

A. Yes.

10

11

Q. Did you have any doubts in your own mind as to the cause of death of any of these children who had been discussed at that meeting?

12

13

A. No.

14

15

Q. Was it your impression that those others who were present at the meeting were similarly satisfied with the discussions that had taken place, or did there appear to be a lingering concern with respect to any of those children?

16

17

18

A. No, I thought there was an explanation.

19

20

Q. I ask you about your impression of the others at the meeting and perhaps you are not able to assist us. Insofar as you are aware did others when they left the meeting have a remaining concern as to what had caused the deaths of any of

21

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those children?

3

A. I can't recall, I don't

4

remember.

5

Q. You know that there was a

6

second meeting held approximately two weeks later

7

on September 26th, were you in attendance at that

8

meeting?

9

A. No, I was not.

10

Q. Were you aware that it was

being held?

11

A. Yes, I was.

12

Q. To the best of your recollection,

13

once again did the nurses, be it from 4A/4B, were

14

they involved in selecting the cases that were

15

going to be discussed at that meeting?

16

A. No, I don't believe they were.

17

Q. Can you help me as to why you

18

were not at the meeting if you had been at the

19

September 5th meeting?

20

A. I am not sure, I don't know

21

if I was working or not, or not at work, I don't  
know what the reason is.

22

Q. After the meeting on September

23

26th, did you have occasion to see the minutes from

24

that meeting?

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A. Yes, I did.

Q. And did you discuss the results of the meeting with Miss Costello?

A. No, I didn't.

Q. Did you discuss it with Mrs. Liz Radojewski, the head nurse from 4A?

A. No.

Q. Do you know what other nurses from Wards 4A/4B were at that meeting?

A. I can't recall now.

Q. Do you know in fact what children were discussed at the meeting?

A. I believe Velasquez was one of the children.

Q. Just to assist you, Dion. Shrum's death was discussed at the meeting, as was Kelly Monteith's. When you saw the minutes of the meeting and perhaps it would be of assistance if you had them, it is Exhibit 51, Mr. Registrar; at page 1 of the minutes, Ms. Bell, there is a lengthy discussion with respect to Velasquez. Do you remember when you first saw these minutes?

A. It was a short time after this was printed.

Q. Was it because of the





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content of these minutes that you came to understand that it had been suggested that an adverse reaction to Narcan had caused that child's death?

A. Yes.

Q. After you had seen the minutes, did you discuss either with your head nurse Mary Costello or any of the members of your own team, what the view as expressed at the meeting had appeared to be concerning Velasquez?

A. No.

Q. Did you raise the matter with any of the cardiologists?

A. No, I didn't.

Q. To the best of your knowledge after that meeting on September 26th was there any further discussion amongst the cardiologists or the nurses as to what had caused that child's death?

A. Not that I am aware of, no.

Q. You yourself didn't raise it again?

A. No.

Q. Neither would the cardiologists or any other nurses?

A. No, I didn't.

Q. Was the matter discussed with







CC8

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any of the nursing supervisors insofar as you are  
aware?

3

4

A. No.

5

6

7

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9

10

Q. The day before that meeting  
took place, Ms. Bell, Brian Gage died on Ward 4A,  
he died approximately 4 o'clock in the morning on  
September 25th. It is my understanding that you  
were on duty on the long night shift on September  
24th, the night he died; do I have that correctly?

11

A. Yes.

12

13

14

Q. Once again can you put yourself  
back if you would please to the start of that shift  
on September 24th. Can you help us as to what Brian  
Gage's condition was at the beginning of that shift?

15

A. I can't recall.

16

17

Q. Do you have any clear recollec-  
tion in your own mind as to whether or not that  
child was regarded as being seriously ill?

18

A. No, I can't.

19

20

Q. Do you know whether he was  
regarded as being stable, no recollection at all?

21

A. I don't have any recollection.

22

23

Q. Did you have occasion to  
personally see him during the course of that shift?

24

A. Just during the arrest.

25





CC9

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Q. How did that come about?

3

A. The same type of situation,

4

a 25 was called. I went into the room and I believe  
the arrest notes are mine.

5

6

Q. Perhaps you could look at the  
medical chart; Mr. Registrar, it is Exhibit 61.

7

8

Were you in the room before the  
Code 25 was called on Brian Gage?

9

A. I don't know.

10

Q. Do you have any recollection

11

of having seen the child before he went into arrest?

12

A. Not that I can recall, no.

13

Q. How did it come about that you

14

went in when the arrest was called?

15

A. I would hear the Code 25.

16

THE COMMISSIONER: You always do go  
in, do you not?

17

THE WITNESS: Yes.

18

THE COMMISSIONER: Do all nurses

19

who are not constant care, do they all go, or just  
the team leaders?

20

THE WITNESS: All the nurses.

21

MS. CRONK: Q. I'm sorry, all

22

the nurses from Ward 4B go into a patient's room if  
a Code 25 was called?

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CC10

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A. Depending on what they are doing, yes.

Q. What happens to the patients for whom they are supposed to be caring?

A. There is somebody left on the floor looking after the patients, not everyone will go, the odd nurse is left to look after the patients.

Q. How is it determined who stays behind and who goes to the arrest?

A. Generally if you are not in the middle of doing something the nurses will go, and then you will look around and assess who is needed, and if you are not needed you will just go back to your ward, or the team leader will assess whether or not who will go back and make sure there is somebody out on the floor.

Q. When you did enter Brian Gage's room, do you recall what his condition was at that time?

A. No, I can't.

Q. Do you recall who was there?

A. Not off-hand, no.

Q. Do you recall any physicians being present by the time you got to the room?

A. No.





Bell, dr.ex.  
(Cronk)

CC11

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Q. Was the crash cart in the  
room?

4

A. I believe it was.

5

6

Q. Do you recall what nurses  
from Ward 4A were in the room?

7

A. No, I can't.

8

9

10

11

Q. Could you turn to page 66 of  
the medical chart, there is a list there again of  
various medications and drugs that were administered  
during the resuscitation attempt on this child, do  
you recognize the handwriting?

12

A. It's mine.

13

14

Q. You then kept a list of  
the medications that were administered to this child?

15

A. Yes, I did.

16

17

Q. Did you remain for the entire  
resuscitation procedure until he was pronounced dead?

18

A. Yes.

19

20

21

Q. Did you observe at any point  
during that resuscitation effort any symptom which  
the child was displaying or exhibiting that you  
regarded as unusual?

22

A. No.

23

24

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Q. Was there anything in the  
way that he appeared to be dying that struck you as





Bell, dr.ex.  
(Cronk)

CC12

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out of the ordinary?

A. Not that I can recall, no.

Q. Would you look please at page 104 of the medical chart. Once again I would ask you to outline for us please if you could the medications that are recorded as having been given to the child during that night shift?

A. Lasix 5 milligrams given at 2100 and --

Q. I'm sorry, go ahead.

A. Do you want the name?

Q. Yes.

A. By Mrs. Scott. Aldactone 5 milligrams given by mouth at 2100 by Mrs. Scott; sodium Sulamyd ointment was given to both eyes at 10 o'clock by Mrs. Scott as well.

Q. Am I correct that the digoxin dose that would otherwise have been given at 9 o'clock on the 24th was held?

A. Yes, it was.

Q. The only medication, I'm sorry, the last medication that is recorded as having been given is that recorded at 10 o'clock that evening?

A. Yes.

Q. And namely the ointment for





Bell, dr.ex.  
(Cronk)

CC13

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the eyes?

3

A. Yes.

4

Q. Both other drugs were given

5

at 9 o'clock in the evening?

6

A. Yes, they were.

7

Q. Did you see any of those

8

medications being administered to the child?

9

A. No, I didn't.

10

Q. To the best of your knowledge

was the child on intravenous?

11

A. Not that I can recall.

12

Q. Do you recall how he was being

13

fed?

14

A. No, I don't.

15

Q. Could you turn to page 65 of

16

the chart please.

17

A. I have it.

18

Q. I would ask you to look at

19

the long night nursing note at the bottom of the  
page, I suggest the child was being fed by nasal

20

gastric tube and I ask you to confirm that if I am

21

correct, or correct me if I am wrong?

22

A. Yes, he was.

23

Q. We have heard in prior evidence

24

from other witnesses, Ms. Bell, that in error

25





CC14

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Brian Gage received a double dose of digoxin in the early hours of the morning on September the 24th, he received a dose of digoxin at 5:30 in the morning and another one at 9 o'clock in the morning; were you aware that that medication error had occurred?

A. No, I wasn't.

Q. Did you at any time whether with respect to that incident or any other incident hear that Brian Gage had received digoxin at a time when he was not scheduled to receive it?

A. No.

Q. After the child died did you have any discussion with the doctors, the physicians who had been in attendance at the arrest concerning the cause of his death?

A. No.

Q. Would you normally after an arrest discuss the arrest with the physicians who had been present?

A. Sometimes we would, yes.

Q. On the basis of the children that we have discussed so far today that happened on a number of occasions did it not?

A. Yes.

Q. But it didn't happen in this one?







CC15

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A. Not that I recall, no.

3

4

Q. Do you recall discussing this child's death with any of the other nurses who had been in attendance?

5

6

A. I don't recall, no.

7

8

Q. Was it your impression that his death was regarded by the nursing staff as unexpected given his clinical condition?

9

10

A. I can't recall.

11

12

13

Q. Was it your own understanding at the time, and impression, having observed the arrest that there was something unusual in the way the child had died, or the time at which he did die?

14

A. No.

15

16

Q. Do you recall any surprise or shock being expressed by any members of the nursing staff or the physicians that the child had died?

17

18

19

20

A. I don't recall, no.

Q. Why did you understand he had died; what did you think was the cause of his death?

21

A. I don't know.

22

Q. Did you lend your mind to it?

23

A. I don't think so, no.

24

Q. Was there any suggestion

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CC16

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raised by any of the physicians and the nurse of  
which you are aware as to why the child had died?

A. Not that I am aware of.

Q. And Tony Adamo was another  
small boy who died on Ward 4A in mid-October,  
Ms. Bell, he died on October the 19th, does that  
name ring a bell with you?

A. The name does, yes.

Q. Do you remember the child?

A. No, I don't.

Q. He died on 4A as I have  
suggested at 5:45 p.m., it is my understanding you  
were not working that day, is that correct, October  
19th? To assist you, if you look at the 4B WIN  
sheets for October 19th, 1980, it was the week of  
October 13th to the 19th?

A. Right.

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BmB.jc  
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Q. It appears that you were working  
October 17th on the long night shift?

A. That's right.

Q. October 18th on the long night  
shift?

A. That's correct.

Q. But you were not working on the  
night that Antonio Adamo died, that is, the 19th?

A. That's correct.

Q. You didn't return to work until  
the 21st, the long night shift, is that correct?

A. That's right.

Q. When you did return to work on  
the 21st, did you learn that Adamo had died?

A. I don't recall but I probably did.

Q. Well, do you recall any  
discussion concerning this child when you did return  
to work on the 21st of October?

A. I don't recall anything  
specific about it, no.

Q. Do you remember any members of  
your own nursing team who had been in the Hospital  
when you were not, raising with you specific concerns  
as to why that child had died?

A. No, I don't recall.







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Q Do you recall any other 4B  
nurses having done so?

A I don't know.

Q Well, insofar as you were aware,  
Ms. Bell, on the 21st of October, was the cause of  
Antonio Adamo's death or the nature of the arrest and  
resuscitation that had been undertaken a matter of  
discussion amongst the nurses?

A It could have been but I don't  
recall.

Q To assist you, it is our under-  
standing, Ms. Bell, that on October 22nd there was a  
meeting amongst members of Karen Power's nursing team  
at which, amongst other matters, this child's death  
was discussed. Now, Karen Power was a 4B team leader,  
was she not?

A Yes, she was.

Q Like yourself?

A That's right.

Q And did Karen Power or any  
member of her team approach you or in your presence  
discuss any concerns they might have had regarding  
this child's death?

A She had said that they were  
going to have a ward meeting.





DD.3

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Q. All right. Well, when did you  
learn of that?

4

A. I believe at report.

5

Q. On the 21st of October?

6

A. I think so.

7

Q. Did she tell you why a ward  
meeting was going to be held?

8

A. I can't recall specifically why.

9

Q. Well, in the context of being  
told that a meeting was going to be held, were you  
invited to attend it?

12

A. It was being held that evening;  
I was working, so, obviously I couldn't attend it.

13

Q. All right. Why did you think  
the meeting was being held?

15

A. I could have been told at that  
time but I don't recall now why. In going over some  
of the notes I believe it was to discuss whether it  
was Adamo's death, I'm not sure.

18

Q. Well, do you recall the next  
day on October 22nd being made aware as to what had  
happened at that meeting?

21

A. I don't recall, no.

22

Q. Do you remember any discussion  
the next day, October 22nd, as to concern about that  
child's death?

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DD.4

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A. It was written in the  
communication book.

Q. Did you see the entry in the  
communications book?

A. Yes.

Q. Perhaps we had better look at  
that. Would you look please at the Ward 4A  
communications book, Exhibit 300, Mr. Commissioner.

I'm sorry, Mr. Registrar, could you  
show the witness Exhibit 301, which is the Ward 4B  
meeting book.

Did you as a matter of course, Ms. Bell,  
review the ward meeting book on a daily basis for your  
ward?

A. Yes.

Q. Did you review the communication  
books as well?

A. Yes.

Q. Do you have the 4B one there?

A. Yes.

Q. I would ask you to turn if you  
would please to page 7.

THE COMMISSIONER: Of which?

MS. CRONK: I am sorry, it is Exhibit  
301, sir, a separate exhibit. It is at page 7, sir.





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Q. Ms. Bell, do you see the entries there for October 22nd?

A. Yes, I do.

Q. They record, do they not, that a meeting was held amongst the members of Karen Power's nursing team on the 22nd?

A. That's right.

Q. And at that meeting the arrest of Antonio Adamo on October 19th was discussed?

A. Yes.

Q. Do you remember now having had the opportunity to look at these notes having read these entries in the ward meeting book?

A. I recall the meeting, yes.

Q. And do you recall reading the ward meeting book and seeing the entries of this meeting?

A. Yes, yes I do.

Q. There is a suggestion in the first paragraph, is there not, that two nurses on Ward 4A are feeling that the "arrest" was their fault. Do you see that?

A. Yes, I do.

Q. Was it ever suggested to you that any particular nurses from 4A felt that the







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arrest of Antonio Adamo was their fault or in some way had been contributed to by their behaviour?

A. I don't know which two nurses they would be referring to.

Q. Well, did you make any inquiries once you had had an opportunity to read the ward meeting book to find out what was being suggested there?

A. No.

Q. Was it a matter of discussion by you with any of the nurses on Ward 4A?

A. There was some discussion.

Q. Well, did you inquire of the nurses on 4A whether any of them felt they had contributed to the arrest of Antonio Adamo?

A. I didn't know who was feeling that.

Q. I'm sorry, did you ask any of the nurses on Ward 4A whether any of them were feeling that?

A. I believe I asked Phyllis and Susan.

Q. All right. And was there any response forthcoming as to whether particular nurses were concerned over that child's arrest?





DD.7

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A. They hadn't mentioned names, no.

3

Q. Did you have the impression that

4

either of those two women were concerned about the  
arrest?

5

A. Pardon?

6

THE COMMISSIONER: I don't know whether  
you said they hadn't something and I missed the rest.

7

8

MS. CRONK: They hadn't mentioned any  
names, sir.

9

10

THE COMMISSIONER: Oh, I see.

11

MS. CRONK: Q. Was it your impression  
that either of those two women were concerned about  
the child's arrest?

12

13

14

A. They weren't present, so, I don't  
think they would express the same concern.

15

16

Q. I'm sorry, who wasn't present?

17

A. Phyllis and Susan.

18

Q. During the arrest of Antonio Adamo?

19

A. I don't think they were.

20

Q. After the meeting on October 22nd,  
do you recall discussing this matter any further with  
Karen Power?

21

A. No, I don't think so.

22

Q. Did she tell you that a further  
meeting was being planned amongst your team members

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for the next day, October 23rd?

A. She could have but I don't recall.

Q. Now, do you recall any of the nurses on your own team being invited to a meeting on the 23rd to discuss the deaths that had been occurring?

A. Other members, yes.

Q. Did any of your team members attend that meeting?

A. No.

Q. I'm sorry?

A. No.

Q. Do you know whether or not there was amongst your own team members as a result of the meeting on the 23rd of October concern regarding the death of Antonio Adamo?

A. Not that I'm aware of, no.

Q. Was it again after October 22nd a subject of discussion by you either with Mrs. Trayner or Ms. Nelles?

A. I'm sorry?

Q. After October 22nd you have told us that you spoke to Phyllis Trayner and Susan Nelles on that day about this death?

A. Yes.

Q. After that day did you again







DD.9

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discuss Antonio Adamo's death with them?

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A. No, I didn't.

4

Q. Just to assist you, Ms. Bell,

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you will recall that I told you that Antonio Adamo

6

died on October 19th and the timing of his death as

7

I recall it was at 5:45 p.m. in the afternoon and

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Phyllis Trayner on October 19th was working the long

9

day shift, according to the 4A WIN sheets, she there-

10

fore would have been on duty at the time of that

11

child's death?

A. October 24th?

12

Q. October 19th.

13

A. I'm sorry, the 19th.

14

Q. Okay.

15

A. She was on long days, yes.

(2)

16

Q. It does not however appear that

17

Susan Nelles was, she came on duty that night on

18

long nights?

A. Yes.

19

Q. As did Sui Scott?

20

A. That's correct.

21

Q. Well, during the course of your

22

discussion with Phyllis Trayner on October 22nd, did

23

she personally express to you any concerns about this

24

child's arrest?

25





DD.10

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A. I can't recall.

3

Q. All right.

4

A. I don't know.

5

Q. Were there at this time as well

6

insofar as you were aware, Ms. Bell, interpersonal  
problems amongst some of the 4A/4B nurses on the wards?

7

A. There were some problems, yes.

8

Q. Were there at this time as well

9

concerns regarding the behaviour of certain nurses

10

during the course of the arrests and resuscitation of

11

a number of these children?

12

A. There was.

13

Q. And was it at this point in time,

14

that is, mid-October, that those matters were  
discussed?

15

A. I believe they were, yes.

16

Q. You told us earlier this morning

17

that there had been concern of which you were aware

18

concerning the suggestion that Code 25's might be

19

called by Phyllis Trayner earlier than other nurses

20

might have done so and you have told us as well that

21

there was concern with respect to the starting of

22

cardiopulmonary resuscitation perhaps earlier than

23

others would have done it. Other than those two

24

matters, do you recall any other concerns at this

25





DD.11

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time regarding Phyllis Trayner's behaviour?

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THE COMMISSIONER: Wait a minute, she hasn't yet said it was anything to do with Phyllis Trayner.

6

MS. CRONK: I'm sorry.

7

8

THE COMMISSIONER: The concerns that you had, were they concerning Phyllis Trayner?

9

10

THE WITNESS: They were.

THE COMMISSIONER: Yes, all right. Now, having said that ---

11

12

13

MS. CRONK: I'm sorry, sir, I had thought I understood to say this morning that the concerns related to Phyllis Trayner.

14

15

16

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THE COMMISSIONER: Well, she did say that this morning about this other but she hadn't said anything about Phyllis Trayner on this one. All right, apparently it is, so, go ahead, tell me what the concerns are.

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THE WITNESS: Our concern was amongst my team members that her reaction to the number of deaths and the arrests were slightly different than ours in that she sought more attention than we did and it was hard for us to deal with it in the same manner. We would discuss things right after the arrests and perhaps go over things and things that we







DD.12

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could have corrected or whatever, that we felt that  
Phyllis would go on and on about it.

3

4

THE COMMISSIONER: I'm sorry, I don't  
understand that? You said her reaction was different  
than yours, she sought more what?

5

6

THE WITNESS: She sought more reassurance,  
she was more vocal with her questions, I suppose.

7

8

THE COMMISSIONER: Well, the deaths were  
on her ward.

9

10

THE WITNESS: That's right.

11

THE COMMISSIONER: As opposed to yours?

12

THE WITNESS: That's right.

13

THE COMMISSIONER: Wouldn't it follow  
that she would seek some ...

14

15

THE WITNESS: But she was louder than  
the rest of her team members who were on for the same  
arrests.

16

17

MS. CRONK: Q. When you say louder,  
Ms. Bell, I take it from what you have said that one  
of the things that Ms. Trayner was doing as a result  
of her concern with respect to these arrests and the  
increased number of arrests was talking about the  
arrests themselves?

18

19

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A. That's right.

23

Q. Would I be fair in assuming that

24

25







DD.13

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that was certainly a matter of discussion amongst the  
other nurses as well?

3

4

A. Yes, definitely.

5

6

Q. Was it then a case where Phyllis  
Trayner appeared to be talking about them more  
frequently than other nurses?

7

8

A. Yes, she was.

9

10

Q. Was that a source of discontent  
or discomfort to the other nurses?

11

12

A. It was a source of discomfort.

13

14

Q. Was there at that time insofar  
as you were aware any other concerns regarding  
Phyllis Trayner's behaviour regarding these arrests?

15

16

A. No, not that I'm aware of.

17

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Q. You told me this morning that you  
were not aware, nor were you made aware by any of the  
members of the nursing staff of any particular  
incident that might have arisen during the arrest and  
resuscitation of Amber Dawson. Do you recall having<sup>e</sup>  
said that this morning?

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A. Yes.

Q. After the death of Antonio Adamo,  
were you made aware by any members of the nursing  
staff of any particular incident that had arisen  
during his resuscitation that had caused difficulty?





DD.14

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A. During Adamo's death?

3

Q. Yes.

4

A. Not that I'm aware of.

5

Q. During his resuscitation?

6

A. No.

7

Q. Was it after Adamo's death that these problems surfaced and were discussed about?

8

A. I'm not sure when the problems

9

surfaced.

10

Q. Do you recall it being discussed

11

before mid-October?

12

A. It was discussed amongst us to

13

some extent.

14

Q. Before mid-October?

15

A. I believe so, yes.

16

Q. Were there concerns as well

17

about the behaviour of any of the other nurses on Phyllis Trayner's team concerning these arrests?

18

A. No.

19

Q. Were there concerns expressed

20

either by any of your own team members or by any of the 4A nurses concerning the behaviour of any member of your own team with respect to any of these arrests?

21

22

A. Not that I'm aware of, no.

23

Q. Was the problem then as it existed

24

25





DD.15

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centred around Phyllis Trayner?

3

A. It did.

4

5

6

Q. Was there any other matter that formed part of the problem or concern that was being expressed by the nurses at this time regarding her behaviour other than what you have told us?

7

8

A. No, nothing, not that I can think of now.

9

10

11

Q. Were there as well at this time, Ms. Bell, as you recall it discussions regarding the merits of splitting up Phyllis Trayner's nursing team?

12

13

A. I'm not sure of the exact date but it was discussed.

14

15

16

17

Q. And do you recall it being discussed prior to mid-October, 1980?

18

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A. It could have been, I'm not sure.

Q. You don't recall one way or the other?

A. No, I don't.

Q. Do you recall specifically that it was discussed in mid-October, 1980?

A. I know it was discussed but I can't place it in time.

Q. Well, I suggest to you that it was discussed at least on October 23rd at the meeting







DD.16

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attended by various members of Karen Power's nursing team, and I would refer you again to the Ward 4B meeting book and the entry for October 23rd at page 8. Do you see that?

6

A. Yes, I do.

7

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Q. There is a reference in these notes that the suggestion that Karen Power's team did not want to be broken up. The first paragraph of the notes, Ms. Bell.

10

A. That's right.

11

12

13

Q. Do you recall it ever being suggested that Karen Power's team should be broken up in isolation from Phyllis Trayner's team?

14

15

A. I don't recall discussing that it should be just Karen Power's team that be split up.

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Q. Well, was the suggestion with respect to the breaking up of nursing teams centred around the breaking up of Phyllis Trayner's team? Was that the team under discussion?

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A. I don't think it was that specific team because we worked - it was the 4A team and the 4B team that worked side by side, so it would be if you were going to break up a team you would be breaking up everyone.

Q. You would have to break up the 4B team to introduce a new person to Phyllis Trayner's team?

A. Yes, you would have to do quite a bit of breaking up a team.

Q. Do you recall who first suggested that Phyllis Trayner's nursing team should perhaps be broken up?

A. It wasn't made with reference just to Phyllis Trayner's team. It was made with reference to my team as well.

Q. Do you recall when it was first raised and by whom?

A. The first person that I recall raising it was Dr. Michelle Heilbut. She was one of the cardiology Fellows.

THE COMMISSIONER: Doctor?

THE WITNESS: Heilbut.

MS. CRONK: Q. Do you know why she was suggesting it might be advisable to do that?





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A. What she had said was that there was quite a bit of stress that arose from the number of deaths and in splitting up the teams perhaps you could alleviate some of that stress.

Q. As I understand it the teams were in fact not broken up; is that correct?

A. No, they were not.

Q. Can you help me as to why it was not done?

A. I guess it was felt it was not necessary.

Q. What was your own view on that? Did you think it advisable that they should be?

A. I felt we got support from each other. It was a stressful time but then we had support as well. I didn't think that anything would be accomplished by splitting up the teams.

Q. Was there reluctance insofar as you are aware expressed by members of your own team at the prospects of working on Phyllis Trayner's team?

A. We worked with her anyway side by side, so I can't see that as a concern of splitting up.

Q. My question to you was so far







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as you can recall it do you remember reluctance  
being expressed by any members of your team at the  
prospect of being assigned to Phyllis Trayner's team?

A. There was no concern.

Q. Do you recall any concern or  
reluctance of that kind being expressed by any of  
the other Ward 4B nurses?

A. There was concern that the  
team that worked the particular shift which would be  
the 4B team and the 4A team was jinxed.

Q. All right. For that reason  
was there a reluctance of which you were aware amongst  
the Ward 4B nurses to serve on Phyllis Trayner's  
team?

A. It wasn't to serve just on  
Phyllis Trayner's team. It was both our teams.

Q. To work on either yours or hers?

A. That is right.

MS. CRONK: Would now be an  
appropriate time, sir?

THE COMMISSIONER: Yes. What has  
happened to the travelling coffee cart? Is it  
available now or is it not?

MS. CRONK: I don't know, sir,  
but if you like I could make enquiries.







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THE COMMISSIONER: The Registrar  
who knows everything says it is not available. I  
think we will take 20 minutes.

---Short recess.

---Upon resuming.

THE COMMISSIONER: Yes, Miss Cronk?

MS. CRONK: Yes, thank you,  
Mr. Commissioner.

Mr. Registrar, could you show Ms. Bell  
Exhibit 309?

Q. Ms. Bell, at about the same  
time that these concerns were being expressed by  
other members of the nursing staff regarding both  
the number of arrests and what was perceived to be  
the behaviour of Phyllis Trayner concerning the  
arrests, did you yourself have occasion to discuss  
the matter with Mary Costello your head nurse?

A. I discussed it with her I  
believe in October.

Q. Did you yourself have concerns  
about working opposite to Phyllis Trayner's team?

A. I didn't have that concern,  
no.

Q. I'm sorry?

A. I didn't have that concern, no.





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Q. May I refer you to page 3 of Exhibit 309? These are handwritten notes which Miss Costello has told us she made in the latter part of March, 1981, or early April, 1981, recording her recollection of certain events at the Hospital?

A. Yes.

Q. On page 3 about the fifth line down the following appears:

"In ? October while doing Bertha's evaluation, Bertha expressed concern and stress re working on team parallel to Phyllis because of Phyllis' behaviour re arrests and her expectations of everyone at this time."

Ms. Bell, do you recall in October of 1980 at the time of your evaluation being prepared by Miss Costello expressing concerns to her regarding working opposite to Phyllis Trayner's team on 4A?

A. Well, there was obvious concern but not to the point of wanting to be switched to another team or not working opposite her.

Q. Did you have personal concerns about working opposite Phyllis Trayner's team at this time because of the number of arrests?

A. There were certain concerns, yes.





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Q. I'm asking you, Ms. Bell, about  
your own concerns.

4

A. Yes.

5

Q. What were they?

6

A. Well, as she stated here,

7

Phyllis' reactions to the arrests were having an

8

effect on myself and on the rest of my team and the

9

rest of my team would come to me with their concerns,  
and because of their concerns it would concern me

10

obviously as well.

11

Q. Yes.

12

A. I had a difficult time dealing

13

with the increased number of arrests myself and

14

increase in deaths as well, and I needed some sort

15

of reassurance or whatever at the time as well. I

16

felt I wasn't getting it.

17

Q. What reaction of Phyllis

Trayner to the arrests was a concern in your mind?

18

A. As I said before the sort of

19

rehashing of it over and over again and her being

20

more vocal and thus getting more support, whereas

21

the rest of the team was involved with these arrests

22

and was present at a number of the deaths and we

23

weren't getting the same type of support that we

24

felt we needed as well.

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Q. Did that situation continue on  
in the fall and into November, December?

4

A. It improved.

5

6

Q. And by that it improved in the  
sense of both yourself and your team members receiving  
more support?

7

8

A. Yes.

9

10

Q. And more reassurance about  
what was happening during the arrests?

11

A. Yes.

12

13

Q. And did the situation deteriorate  
again after that or in your own mind did it improve  
and remain improved?

14

15

A. It remained improved, or we  
found a way to deal with things a bit better as well.

16

Q. As a team?

17

A. Yes.

18

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21

Q. May we turn then to the case  
of John Onofre? This child died, Ms. Bell, as you  
may recall on your own ward, on Ward 4B, December 9,  
1980, in the early hours of the morning at approxi-  
mately 4 o'clock.

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It is my understanding you were on  
duty on December 8th during the day but not on the  
long night shift which is when the child died. Is





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2  
3 that correct?

4 A. That is correct.

5 Q. Do you recall having seen  
6 John Onofre during the day on December 8th?

7 A. Yes.

8 Q. Do you remember what his  
9 condition was at that time?

10 A. He was - I believe he was on  
11 a cardiac monitor. He was in isolation I believe.  
12 There was concern but I am not sure, I don't think  
13 he was on constant nursing care.

14 Q. Do you remember whether or not  
15 the child was regarded on December 8th as being  
16 critically ill?

17 A. He was ill, yes.

18 Q. Critically ill?

19 A. Not critically enough to  
20 constitute putting him on constant nursing care.

21 Q. Was it considered, for example,  
22 that his death was likely to occur in the very near  
23 future?

24 A. Not that I know of, no.

25 Q. When you went off was his  
condition relatively stable?

A. It was stable but it was serious.





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3 Q. But it wasn't thought I take it  
4 at that time that he was actually in the process  
5 of dying?

6 A. He wasn't in the process of  
7 dying, no.

8 Q. As I understand it --

9 THE COMMISSIONER: I'm sorry, he was?

10 THE WITNESS: He wasn't in the  
11 process of dying.

12 THE COMMISSIONER: He was not in  
13 the process of dying?

14 THE WITNESS: No.

15 MS. CRONK: Q. As I understand it  
16 although you did not work that evening or on the  
17 night shift you did, however, work days on December  
18 9th?

19 A. Yes, I did.

20 Q. And I take it when you reported  
21 for duty you would have learned of his death over  
22 the night?

23 A. Yes.

24 Q. Do you recall at that time  
25 whether concerns were expressed regarding the  
cause of that child's death or the way in which he  
had died?





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A. There was concern but again this child was in isolation. There was concern expressed by the nurse team that was working that, you know, had they noticed something earlier, the same type of concerns we have anyways, but she had said that she was in the room sort of when his condition did deteriorate.

Q. I'm sorry, who told you that?

A. I believe this Harwood-Jones was looking after her.

Q. All right. Did you take report from her the next morning or was this a separate discussion you had?

A. That was separate.

THE COMMISSIONER: What was it she said?

THE WITNESS: I'm sorry?

THE COMMISSIONER: What was it she said to you?

THE WITNESS: She was concerned about that this child was in isolation and she perhaps wasn't in the room as often as she should have been but she did know it when he was deteriorating.

MS. CRONK: Q. As you understood it did she regard his death that night as unexpected?







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A. I guess she felt it was.

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Q. Did that appear to be the view  
of the 4B nurses in addition to herself who had  
been working that night?

5

6

A. Yes.

7

8

Q. Was there any suggestion raised  
in your presence at any time, Ms. Bell, that  
digoxin toxicity may have been involved in the death  
of this child?

9

10

A. No.

11

12

Q. Was toxicity from any drug  
raised as a possible contributing factor to his  
death?

13

14

A. No.

15

16

Q. Did you ever hear at any stage,  
be it the day after his death or subsequently, from  
any members of the nursing staff that he may have  
received a dose of digoxin not prescribed for him?

17

18

A. No.

19

20

Q. You don't recall any suggestion  
of that?

21

A. No, I don't.

22

23

Q. As I understand it after John  
Onofre died you were absent from the Hospital on  
holidays for the period December 19th, 1980, to

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December 27th, 1980 inclusive?

A. Yes.

Q. Is that correct?

A. Yes.

Q. Prior to your departure on holidays, however, on December 18th, a child by the name of Real Gosselin died at the Hospital on 4A in the early hours of the morning.

Do you have any recollection concerning this child's death or the circumstances surrounding his death?

A. No, I do not.

Q. You were not working at the time?

A. I was working at the time but I don't have any recollection.

Q. Do you recall any discussion following that child's death regarding the cause of his death or the circumstances under which he had died?

A. No, I don't recall.

Q. All right. Do you recall discussing his death or being present when his death was discussed with Dr. Freedom?

A. I don't recall.

Q. When you returned from holidays





1  
2 I take it you were informed that there had been a  
3 number of other deaths on the wards in your absence.  
4 You returned on December 28th; is that correct?

5 A. Yes.

6 Q. Were you informed at that time,  
7 for example, that a child by the name of Stephanie  
8 Lombardo had died on the wards on December 23rd?

9 A. Yes.

10 Q. When did you learn that?

11 A. Upon my return to work.

12 Q. Do you recall who told you of  
13 the child's death?

14 A. No, I don't.

15 Q. Was that a matter that would  
16 be covered normally in the report that you received?

17 A. No, it wouldn't be.

18 Q. Was there any discussion when  
19 you returned to work as to the circumstances under  
20 which that child had died?

21 A. Not that I can recall, no.

22 Q. Do you remember anyone  
23 expressing a concern as to why she had died when she  
24 did?

25 A. No.

Q. Do you recall anyone suggesting







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a concern as to why she had died when she did?

A. No.

Q. Do you recall anyone suggesting in your presence or to you personally that the child may have received a medication or a drug that had not been prescribed for her?

A. No.

Q. Was there ever any suggestion of which you are aware that she may have received digoxin specifically during her stay at the Hospital for Sick Children?

A. No.

Q. As best as you understood the situation on December 28th was her death as well considered to be unexpected?

A. I can't recall. I don't know.

Q. You don't remember any particular concern on the part of any specific nurses with respect to her death?

A. No, I can't.

Q. Did you discuss her death with any of the physicians on the cardiology unit?

A. Not that I recall, no.

Q. By the time you came back on December 28th, in addition to the death of Stephanie





1  
2 Lombardo, there had been four deaths on the wards  
3 that month, and there was another death on the  
4 day that you returned, that of Jesse Belanger?

5 Do you remember that patient?

6 A. No, I don't.

7 Q. He was a patient on Ward 4B.  
8 Do you recall seeing him?

9 A. No, I don't.

10 Q. Then perhaps you could turn  
11 if you would to the 4B WIN sheets for December 28th.

12 Do you have it?

13 A. Yes, I have.

14 Q. According to the WIN sheets,  
15 Ms. Bell, you worked the long day shift on December  
16 28th?

17 A. I did.

18 Q. It appears you were working  
19 in the Intensive Care Unit. Do I have that correctly?

20 A. Yes, that is right.

21 Q. You were posted as relief,  
22 I take it to that ward?

23 A. Yes, I was.

24 Q. In that situation would you  
25 normally have been on your own ward first in order  
to learn that you are being posted as relief to the  
ICU?





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A. Yes.

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Q. Did you have occasion to  
be on your own ward at any point during the day?

5

6

A. I had just returned there  
after my shift in ICU back to the ward.

7

Q. At the end of the day?

8

A. Yes.

9

10

11

Q. And when you returned to your  
ward at the end of the day were you alerted to the  
fact that Jesse Belanger, a patient on Ward B, had  
encountered difficulties?

12

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A. I had learned that there  
was an arrest on 4B because I was in ICU because  
the calls go through to ICU and the doctor that was  
in the room with me while I was in ICU, that is  
where she was headed, so I knew of the arrest from  
being in the unit, and I didn't know who the child  
was, though.

18

19

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Q. When you came back to the  
ward were you made aware of the fact that it was  
Jesse Belanger?

21

22

<sup>2</sup> A. No. They were busy with the  
child and I left.

23

24

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Q. Did you participate at any  
point in the resuscitation of that child?





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A. No, I did not.

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Q. Did you see the child at all  
when you returned to the ward?

5

A. No, I didn't.

6

7

Q. Did you pass the child's  
room while you were on the ward?

8

A. Yes.

9

10

Q. Was the arrest and resuscitation  
in progress at this time?

11

A. Yes, it was.

12

13

Q. Do you recall having had  
discussions when you were next at work concerning  
the death of that child?

14

15

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A. The only discussion was that  
this child had been transferred I believe that day  
from 7G and again perhaps this child shouldn't have  
been transferred and should have been monitored  
more closely. Other than that I don't know of any  
other discussion.

19

20

Q. He was transferred from 7G  
back to 4B on the same day that he died?

21

A. I believe he was.

22

23

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Q. Do you recall any suggestion  
at any time either made to you or in your presence  
that toxicity, be it from digoxin or any other drug,







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might have played any part in this child's death?

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A. No.

4

Q. Do you recall any suggestion

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having been made which you heard or of which you

6

were later informed that the child may have received

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digoxin at any time during his stay at the Hospital

8

for Sick Children?

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A. No.

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Q. Were the medications that he had received an issue in the minds of the nurses? Was the matter under discussion after he died?

A. Not that I am aware of, no.

Q. Do you recall any of your own team members or any of the other 4B nurses expressing the view that this child's death had been unexpected given his clinical condition when he was transferred onto the ward?

A. It was the concern that this child was transferred and should not have been transferred. Other than that, perhaps that the child wasn't stable enough to transfer to the ward.

Q. Was that suggested to you?

A. That was.

Q. Was there any suggestion that given his clinical condition when he did arrive on the ward, notwithstanding the condition, that his death was unexpected?

A. You wouldn't have enough time to assess a situation like that because the transfer would be, you know, you receive a child at transfer and you wouldn't expect the child to arrest because in order to transfer him you think he would be reasonably stable.





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Q. I take it you don't recall

3

any suggestion being raised by any of the nurses --

4

A. No.

5

Q. -- that the time of the death  
was unusual?

6

A. No.

7

Q. By the end of that month, Ms.

8

Bell, there were some 22 deaths on those two wards.

9

Were you aware in your own mind at the time that there  
had been so many?

10

11

A. Not the exact number but

12

that there had been a lot, yes.

13

Q. Were you conscious of the

14

fact that although there had been a great many during

15

the summer, the deaths indeed had continued and in

16

December there seemed to be yet another increase in

17

the deaths?

18

A. Yes.

19

Q. At that time did you discuss

20

the matter of these increased deaths, the continuing

21

increase in the deaths with any of the cardiologists

22

on the wards?

23

A. No, I did not.

24

Q. Could you lend your own mind,

25

Ms. Bell, as to how these children were in fact dying?







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A. I didn't know.

3

Q. Did you consider how it was

4

that they were all dying?

5

A. I considered it.

6

Q. In your own mind did it occur

7

to you at that time, in the face of so many deaths,  
something other than natural causes might have been  
affecting the deaths of these children?

9

A. No.

10

Q. What did occur to you was the

11

explanation for these deaths?

12

A. I didn't know.

13

Q. Was it a matter that was dis-

14

cussed amongst the nurses on your own team?

15

A. Exact causes were not dis-

16

cussed; a concern over the increase, that was dis-  
cussed.

17

Q. And particularly, Ms. Bell,

18

at the end of December when there had been, as I

19

suggested to you, some 22 deaths, was there in your

20

own mind increased stress on the wards at that time  
because of these deaths?

21

A. Yes, there was.

22

Q. Did there seem to be a need

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on the part of the nurses to find out why these

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children were dying?

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A. Yes.

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Q. Were there discussions at that time, either with the cardiologists or senior nursing staff, as to what was accounting for the deaths of these children?

8

A. I don't think there was any formal discussion, no.

9

10

Q. Was it a matter that was particularly worrisome to yourself?

11

A. It was.

12

13

Q. Did any explanation or potential explanation for all of these deaths occur to you at that time?

14

A. No.

15

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Q. Do you recall discussing the matter with your colleague and companion team leader on 4A, Phyllis Trayner?

18

19

A. We discussed the increased number of deaths, yes.

20

21

Q. Was it around this time that you discussed it?

22

A. I don't know.

23

24

25

Q. Do you remember discussing it towards the end of December or the beginning of the





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new year?

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A. It was an ongoing concern with each arrest. There was a concern that these arrests were occurring and that they were occurring when we were there.

Q. Was there any explanation suggested by any of the Ward 4A nurses as to why all these children were dying?

A. No, there wasn't.

Q. Did they seem to be in as much confusion about the matter as you yourself were?

A. Yes. I believe they were.

Q. To the best of your recollection were meetings held by Elizabeth Radojewski about this time to try to determine why all these children were dying?

A. There were meetings held. I can't fix the time.

Q. Did you participate in them?

A. Not that I recall.

Q. Indeed in the month of

January there was yet another death. As you may recall, Ms. Bell, on January 11th Janice Estrella died on Ward 4A. As I understand it, you were on long night duty on January 10th, the night of her





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death.

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A. Yes.

4

Q. Were you aware at the start of  
your shift that evening that Janice Estrella was  
on constant nursing care on Ward 4A?

6

A. Yes, I was.

7

8

Q. Were you also aware as to the  
nature of her condition when you started that shift?

9

A. She was serious, yes.

10

11

Q. Did you discuss her with  
Phyllis Trayner as you had on other occasions?

12

A. Yes, we did.

13

14

15

Q. Other than being told that  
she was in serious condition, were you provided with  
any specifics as to what her condition was at the  
beginning of that shift?

16

17

A. I believe I was but I can't  
recall what the specifics are right now.

18

19

20

Q. Was it thought, as best you can  
recall it, that Janice Estrella that night was in  
particular danger of dying?

21

22

A. She could have been.

23

24

25

Q. Do you recall that view being  
expressed?

A. She was unstable. She was not







1  
FF7 2 doing very well since her surgery and the possibility  
3 was there.

4 Q. She was then I take it on the  
5 seriously ill list for that evening?

6 A. She probably was, yes.

7 Q. Did you have occasion per-  
8 sonally to see her that night?

9 A. I don't recall if I saw her  
10 before the arrest or not.

11 Q. You did see her however at the  
12 time of the arrest?

13 A. Yes, I did.

14 Q. How did that come about?

15 A. Mrs. Scott was looking after  
16 her and she had called out in an urgent voice, so  
17 I was at the desk and I ran down to her and she was  
18 in a single room on her own.

19 Q. What did Mrs. Scott call out?

20 A. I can't recall what she  
21 said, whether it was Phyllis' name or -- I don't  
22 recall.

23 Q. The progress notes of the  
24 medical record for the child suggests that she first  
25 went into difficulty that evening at approximately  
2:40 in the morning. Does that help you in placing





Bell  
dr.ex. (Cronk)

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the time at which Mrs. Scott called out when you entered the room?

A. Yes.

Q. Was it around that time?

A. Yes.

Q. Who was in the room when you entered the room?

A. Mrs. Trayner and Mrs. Scott.

Q. And what was happening in the room when you entered?

A. She was in respiratory difficulty and they were getting oxygen set up and then I believe they had started CPR.

Q. Were there any other nurses in the room other than Mrs. Trayner and Mrs. Scott when you entered?

A. No, not at that time.

Q. Were there any physicians in the room?

A. Not at that time, no.

Q. Did Dr. Schaffer arrive when you were still there?

A. Yes.

Q. What time was that?

A. I don't know, within a couple





Bell  
dr.ex. (Cronk)

FF9

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of minutes.

3

Q. Of your having arrived in the  
room?

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A. Yes.

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Q. At any point during that  
shift, prior to hearing Mrs. Scott cry out and prior  
to yourself going into the room, had you seen anyone  
other than Mrs. Scott go into Janice Estrella's  
room at all, at any point during that night?

10

A. No, not that I recall.

11

12

13

14

Q. At any point during that  
night had you seen anyone administer any medication,  
or drug, or antibiotic, anything of any kind, to that  
child?

15

A. No.

16

17

Q. Do you recall that night at  
any time seeing anyone enter Janice Estrella's room  
carrying a syringe, or what appeared to be a medication?

18

A. No.

19

20

21

22

Q. We know that Janice Estrella  
was on constant care, as you yourself have said,  
that evening and was assigned to the responsibility  
of Mrs. Scott. Do you know who relieved Mrs. Scott  
for her first coffee break that night?

23

A. I don't know.

24

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FF10 2

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Q. Do you know who relieved her  
for her lunch or dinner break?

4

A. I don't know.

5

Q. Do you know whether she took  
one?

6

A. I have no idea.

7

8

Q. Was the matter of who would  
relieve constant care nurses on 4A a matter that  
would normally be discussed between Phyllis Trayner  
and yourself?

10

11

A. And myself, no.

12

13

14

Q. Would you look for a moment  
please at the Ward 4A WIN sheets, Exhibit 335, for  
January 10th, the long night shift. Do you have  
that, Ms. Bell?

15

16

A. Yes, I do.

17

18

19

Q. Am I correctly interpreting  
the sheets if I suggested to you that on the long  
night shift on Ward 4A Mrs. Trayner was on duty,  
Mrs. Scott and Mrs. Christie?

20

21

22

A. And Miss Brownless.  
Q. I'm sorry, and Miss Brownless.  
And of the four women the only two Registered Nurses  
were Phyllis Trayner and Mrs. Scott?

23

24

25

A. That is correct.





1  
FF11 2 Q. If the Registered Nurse  
3 assigned to constant care duties wished to take a  
4 break and to be relieved was it required that a  
5 Registered Nurse as opposed to a Registered Nursing  
6 Assistant relieve her?  
7 A. It was preferred, yes.  
8 Q. Was it in fact the normal rule  
9 on those wards?  
10 A. It was.  
11 Q. Would it be fair, subject to  
12 the evidence that we may hear from those involved,  
13 to assume that in this situation unless a Ward 4B  
14 Registered Nurse had relieved Sui Scott it was likely  
15 Phyllis Trayner?  
16 A. Yes.  
17 Q. To your knowledge did any 4B  
18 Registered Nurse relieve her that evening?  
19 A. Not to my knowledge, no.  
20 Q. Would that be unusual?  
21 A. If the need arose it wouldn't  
22 be, no.  
23 Q. If it did happen and a Ward 4B  
24 nurse was asked to relieve for a coffee break, or  
25 lunch or dinner break, as opposed to just for a few  
moments, would you as the team leader on duty be





FF12

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2

aware of that?

3

A. Yes, I would.

4

Q. Do you have any recollection of

5

a 4B Registered Nurse being asked to relieve Sui

6

Scott that night?

7

A. No, I don't.

8

Q. And you have told us that you

9

were present during the arrest of Janice Estrella.

10

Did you stay throughout the entire resuscitation?

11

A. Yes, I did.

12

Q. And at the end of the

13

resuscitation did you participate in any discussions

amongst the physicians who were present concerning

that child's death?

14

A. Not that I can recall.

15

Q. Do you recall discussing her

16

death with any of the nurses from 4A, Phyllis Trayner,

17

Mrs. Scott, Janet Brownless or Mary Ann Christie?

18

A. No, not that I recall. No.

19

Q. Do you recall discussing it

20

amongst your own team members that night?

21

A. No.

22

Q. Were any concerns expressed

23

of which you were aware as to the cause of that

24

child's death after she had died that night?

25





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FF13

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A. I don't believe there were  
any concerns expressed, no.

4

5

6

Q. Was there any suggestion  
raised of which you were aware, of which you learned,  
that digoxin may have played a part in her death?

7

8

9

10

11

12

A. She had a high digoxin level  
a couple of days previously which I was aware of.  
She had a respiratory arrest I believe it was two  
days prior to this, and they had done their routine  
digoxin levels and the number that comes to mind is  
10 was the level, which was outrageous because I  
had never heard of a level that high.

13

14

15

16

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24

25

Q. This was several days prior  
to her death?

A. Yes.

Q. Yes?

A. And there was just -- we were  
not sure why the digoxin level was so high, that  
she had recovered from the initial respiratory  
arrest, which was a couple of days previous, with a  
level that was high.

Q. Well was there that night,  
that is in the early morning of January 11th, any  
suggestion raised of which you are aware that digoxin  
toxicity may have contributed to her death?







FF14

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A. It could have. There was

3

discussion that it could have contributed.

4

Q. And did that take place that

5

morning?

6

A. After the arrest, yes.

7

Q. Who suggested that as a

possibility?

8

A. I believe it was Dr. Schaffer.

9

Q. Were you present when he did?

10

A. Yes.

11

Q. Who else was present?

12

A. I believe Mrs. Scott and

Phyllis Trayner.

13

Q. Were any other physicians

14

there?

15

A. The Resident was there as well.

16

Q. Do you recall who that was?

17

A. No, I can't recall right now.

18

Q. Was it Dr. Amanda Tucker?

19

A. It could have been.

20

Q. You don't recall one way or

another?

21

A. No, I don't.

22

Q. What specifically did Dr.

23

Schaffer say in that connection?

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FF15

A. Just that she had had a high dig. level and I believe her digoxin was on hold, but she had an unusually high digoxin level.

Q. Did Dr. Schaffer suggest that digoxin toxicity may in fact have contributed to or caused her death?

A. He could have, yes. He did.

Q. Did he at that stage -- during that discussion was there any suggestion by him, or by anyone else present, that a digoxin level at that stage should be taken?

A. I don't recall. It could have been. I don't know.

Q. Do you recall whether or not the suggestion was made that a blood sample should be taken for that purpose?

A. I don't recall him specifically stating, but it would have made sense.

Q. Did Dr. Schaffer indicate in any way that further enquiries were going to be made to determine if digoxin toxicity had in fact contributed to her death?

A. Not that I am aware of .

Q. To the best of your recollection was Dr. Freedom there during this discussion





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FF16 2 that took place with Dr. Schaffer?

3

A. I don't recall Dr. Freedom  
4 being there, no.

5

Q. Do you recall him being  
6 there at any point during the resuscitation or  
7 arrest of this child?

7

A. I don't recall.

8

Q. Do you recall seeing him  
9 on the ward at all that morning?

10

A. I don't recall.

11

Q. Did the matter of the possible  
12 involvement of digoxin toxicity with respect to the  
13 death of Janice Estrella come up again after that  
14 morning?

14

A. No, it didn't.

15

Q. Do you recall whether or not  
16 you informed Miss Costello that that was a matter  
17 that had been raised by Dr. Schaffer?

18

A. No, I hadn't.

19

Q. Was the matter raised by you  
20 with any of the cardiologists on the unit after  
21 the discussion with Dr. Schaffer?

21

A. No, it wasn't.

22

Q. Did you discuss it again with  
23 Dr. Schaffer himself?

24

25







Bell  
dr.ex. (Cronk)

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FF17 2

A. No, I didn't.

3

Q. You did not?

4

A. No.

5

Q. Do you know whether any  
efforts were made by him to explore the matter further  
at that stage?

7

A. No, I don't know.

8

Q. Did any of the nurses who  
were present, that is Phyllis Trayner and Sui Scott,  
raise the matter with you again?

10

11

A. No, I don't believe they did.

12

Q. When did you first learn,  
Ms. Bell, that a blood sample for testing for digoxin  
had been taken on Janice Estrella and that a level  
had in fact been tested?

13

14

15

A. Not until after the investiga-  
tion was started.

16

17

Q. What do you mean by that?  
Was it before or after Susan Nelles was originally  
arrested?

18

19

A. It was after Susan Nelles  
was arrested.

20

21

Q. From whom did you learn that  
Janice Estrella had a high digoxin level that had  
been tested?

22

23

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25





FF18

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A. From the police.

3

Q. Did you learn at that time

4

that it was an elevated, very high level?

5

A. Yes.

6

Q. During that entire time

7

from January 11th, the morning of Estrella's death,

8

until after Susan Nelles was arrested, did you

9

participate in any further discussions at all

10

concerning Janice Estrella's death?

A. No, I didn't.

11

Q. Was there at any time during

12

that period any suggestion that the question of

13

digoxin toxicity may have caused the child's death,

14

other than the suggestion raised by Dr. Schaffer

15

the morning she died?

A. Not that I am aware of, no.

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BmB.jc  
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Q Was there any time when  
Dr. Freedom or any of the other cardiologists raised  
that matter with the nurses insofar as you are aware?

A Not that I'm aware of, no.

Q Could I ask you to turn to  
Janice Estrella's medical chart if you would, please.  
It is Exhibit 91, Mr. Registrar. Could you turn to  
page 53 please, Ms. Bell?

A I have it.

Q Could you help me please as to  
what medications are recorded as having been given to  
Janice Estrella during the night shift on January 10th  
or early in the morning of January 11th?

A Warm saline soaks were given to  
the incision at 10 p.m. by Mrs. Scott; ampicillin 75  
milligrams I.V. was given midnight by Mrs. Scott.

Q Can we stop there for a moment?

A Sure.

Q Over the signature of Mrs. Scott  
which appears beside the time for that particular  
medication.

A Oh, I'm sorry.

Q As I read it the numbers are  
0130.

A I'm sorry, she was given the





GG.2

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ampicillin at 1930, that would be 7:30 in the evening  
and again at 1:30 both by Mrs. Scott.

4

Q All right. Did she receive any  
other medication that night?

5

6

A And she got aldactazide by mouth  
at 10 p.m. by Mrs. Scott.

7

8

Q I'm sorry, by Mrs. Scott?

A Yes.

9

Q And 4 milligrams?

10

A I'm sorry, yes.

11

Q All right. Could you turn if you  
would please to page 128. This is the nursing note  
made apparently by Mrs. Scott during that long night  
shift on January 10th. Perhaps you can help me but as  
I read it there is no indication of any other  
medication having been given to the child that  
evening other than the ones we have just reviewed in  
the Medication and Treatment record, is that correct?

12

13

14

15

16

17

18

A That's correct.

19

Q It does however appear that the  
child was being fed by nasogastric tube.

20

21

A Yes.

22

Q If the entries on the Medication  
and Nursing Treatment record be correct, am I inter-  
preting them correctly, Ms. Bell, if I suggest then

23

24

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that the last recorded medication that the child received was 75 milligrams of ampicillin administered at 1:30 in the morning by Mrs. Scott?

5

A. That's correct.

6

7

Q. At any time between 1:30 in the morning and 2:40 -- I'm sorry, sir?

8

THE COMMISSIONER: Yes, all right, yes, I take it back.

9

10

11

12

MS. CRONK: Q. At any time, Ms. Bell, between 1:30 in the morning and 2:40 in the morning, that's the time of the child's arrest, did you observe anyone administering a medication to this child?

13

A. No, I didn't.

14

15

Q. Did you see Mrs. Scott administering the medication at 1:30 in the morning, the ampicillin?

16

A. No, I didn't.

17

18

Q. Did you see the aldactazide being administered by Mrs. Scott earlier in the evening?

19

A. No, I didn't.

20

Q. Could you turn to page 126 of the chart as well if you would, please?

21

A. Yes, I have it.

22

23

Q. This is the cardiac arrest note as I understand it completed by - is that Dr. Tucker?

24

25





GG.4

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A. Yes, it is.

3

Q. I'm sorry, it is the page before

4

that I am interested in, they are both numbered 126

5

A. Oh, okay.

6

Q. I'm sorry. This is the nursing

7

note for the child made from 7 a.m. to 7 p.m. on

8

January the 10th. I am interested particularly in the  
entries concerning Janice Estrella's I.V. apparatus.

9

About two-thirds the way down the page beside the

10

initials I.V. it reads "interstitial at 1645". Do you

11

see that?

12

A. Yes, I do.

13

Q. And it then reads, is it

discontinued at that time?

14

A. Yes, yes.

15

Q. Restarted at 1800 hours, however,

16

went interstitial again?

17

A. Correct.

18

Q. Can you help us please, what

19

does it mean when it is indicated that an I.V. has  
gone interstitial?

20

A. That the needle has moved out

21

of the vein, so, the fluid is not being absorbed at

22

all, it is being absorbed probably just underneath

23

the skin, you will see a swelling or you will see a

24

25





GG.5

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redness, depending what fluid is going through the  
needle.

3

4

Q Can that happen if the child or  
the patient moves in such a way as to dislodge the  
needle?

5

6

A Yes, it could.

7

8

Q All right. And if the needle had  
become completely dislodged from the patient would the  
I.V. also be described as interstitial?

9

10

A It could.

11

12

Q In either situation, whether it  
had become dislodged from the vein or had come away  
entirely from the patient, is there - well, in the  
first situation if it had just moved away from the  
vein, is it possible that any of the fluid flowing  
through the I.V. apparatus could still reach the  
patient?

13

14

15

16

17

A Some of it could, yes.

18

Q But in a vastly reduced amount?

19

A It would depend on the degree  
of how it was in the vein.

20

21

Q All right. And given that the  
indication in the progress notes suggests that the I.V.  
line on Janice Estrella went interstitial on two  
occasions.

22

23

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GG.6

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A. Yes.

3

Q. Yet at the same time as we have

4

seen it appears that Mrs. Scott administered

5

ampicillin at 1:30 in the morning intravenously, it

6

appears that some time between 1800 hours in the

7

evening and 1:30 in the morning her I.V. apparatus

was reconnected?

8

A. Yes.

9

Q. Do you recall any discussion, be

10

it with Phyllis Trayner or any of the other nurses

11

on 4A, that there were difficulties during that late

12

night shift concerning Janice Estrella's intravenous

13

line?

14

A. No, I don't.

15

Q. That wasn't a problem brought to

16

your attention?

17

A. No, it wasn't.

18

Q. After Janice Estrella's death

19

was the matter raised with you by Sui Scott at any

20

time?

21

A. With reference to the intravenous?

22

Q. Yes.

23

A. No.

24

Q. Do you recall any discussion

25

that evening after Janice Estrella died with





GG.7

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4

Dr. Schaffer or any of the nurses from Ward 4A as to whether or not her death should be reported to the coroner?

5

A. I don't know of such discussion, no.

6

7

8

9

Q. It has been suggested to us in prior evidence that Dr. Schaffer contacted the coroner when Janice Estrella died. Were you aware of that?

10

A. No, I wasn't.

11

12

Q. I take it then that didn't happen in your presence?

13

A. No.

14

Q. Nor were you informed that it had?

15

A. No.

16

Q. All right. Could we turn then to the case of Frank Fazio.

17

THE COMMISSIONER: Miss Cronk, it is now ...

18

19

MS. CRONK: You're quite right, sir, I won't be able to complete that this evening.

20

21

THE COMMISSIONER: No. Well, I think we will rise until 10 o'clock tomorrow morning.

22

MS. CRONK: Thank you.

23

MR. TOBIAS: Mr. Commissioner, for some

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GG.8

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of us who may be in difficulty tomorrow, could we  
have some idea of when Miss Cronk anticipates  
finishing?

4

5

THE COMMISSIONER: Yes, how long do you  
think you will be?

6

7

MS. CRONK: I think I will take the  
full morning, sir.

8

9

THE COMMISSIONER: Yes. Miss Kitley,  
how long will you be?

10

MS. KITLEY: Perhaps an hour, sir.

11

THE COMMISSIONER: Is that enough for  
you, Mr. Tobias?

12

13

MR. TOBIAS: Yes, that's fine, thank you,  
sir.

14

15

THE COMMISSIONER: Yes, all right.

16

--- Whereupon the Hearing was adjourned at 4:30 p.m.  
until 10:00 a.m., Tuesday, February 7th, 1984.

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